Guiding change in the Irish health system
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The Irish health system is currently engaged in an ongoing process of change and transformation at every level. The key focus is to ensure that all our resources are directed towards better services for our population. The HSE Transformation Programme 2007-2010 clearly outlines our fundamental purpose: ‘to enable people live healthier and more fulfilled lives’. It also outlines our vision for the future:

‘Everybody will have easy access to high quality care and services that they have confidence in and staff are proud to provide.’

This programme of transformation of our health and social care services calls for a change in not only what we do, but in how we do things and how we work together to deliver integrated patient centred services. As we continue to make progress, guiding and leading change across the whole system is a key challenge for everyone in the health services. We are committed to meeting this challenge and to continuously seek ways to improve how we do things.

In the Organisation Development and Design Directorate we are focused on ensuring that staff are supported to gain the knowledge, skills and confidence to approach change in a way that improves the prospect of a good outcome for all involved. A key element of our approach is to provide resource materials to assist staff to understand the relevant theory and to offer guidance on how change is planned, implemented and sustained. In this regard, this literature review presents valuable insights and guidance on approaches to change. Therefore, we can bring about improvements by learning from the literature and basing our decisions on evidence. This will, we hope, provide a basis for assisting, planning and managing change.

It is intended that this literature review, which is based on current thinking, will be a good starting point for guiding change interventions. We intend to build on this by developing practical resource materials that will assist staff at all levels to bring about real and lasting change.

Finally, as we seek to continuously improve our thinking and our practice, I hope this literature review will assist you in planning and managing change and on focusing on the most effective ways to manage and lead the transformation programme.

Síle Fleming
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COMMISSIONING OF LITERATURE REVIEW

Organisation Development and Design in the HSE Dublin North East Area commissioned the Health Policy and Management Unit in Trinity College Dublin to carry out a literature review in relation to change management within an organisation development frame of reference.

It was recognised that there is a significant body of academic literature in relation to change in the broadest sense and within a health and social care context. It was intended that the process of developing the literature review would bring together the most up-to-date and relevant thinking, provide a considered analysis of the literature and present it in a way that is accessible to managers and staff.

Purpose
The purpose of this literature review is therefore to provide a comprehensive overview of current thinking in relation to theoretical change models, approaches to change, tools for change and key factors for enabling and managing change in the current climate. The purpose is also to assist us in having an evidence base and strong platform for our interventions to support the transformation programme.

This literature review can be used as a resource to guide managers and staff in planning and implementing successful change processes. It can also act as a key reference point to influence and shape change interventions at different levels in the system.

Caitríona Heslin
Head of Organisation Development and Design
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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>PART</th>
<th>INTRODUCTION</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>PART 2</td>
<td>CHANGE IN THE IRISH HEALTH SERVICES</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>2.1 Health Services National Partnership Forum (HSNPF)</td>
<td>7</td>
</tr>
<tr>
<td>PART 3</td>
<td>THEORETICAL CHANGE MODELS</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>3.1 Planned models</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>3.2 Systems models</td>
<td>14</td>
</tr>
<tr>
<td>PART 4</td>
<td>APPROACHES TO CHANGE</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>4.1 Top down versus bottom up</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>4.2 Mixed planned/emergent</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>4.3 Organisation development</td>
<td>31</td>
</tr>
<tr>
<td></td>
<td>4.4 Change typologies</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td>4.5 Matching strategy to approach</td>
<td>35</td>
</tr>
<tr>
<td>PART 5</td>
<td>TOOLS FOR CHANGE</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td>5.1 Tools that assist in understanding organisational problems</td>
<td>41</td>
</tr>
<tr>
<td></td>
<td>5.2 Tools that assist in assessing capacity for change</td>
<td>46</td>
</tr>
<tr>
<td></td>
<td>5.3 Tools that assist in the action of achieving change</td>
<td>50</td>
</tr>
<tr>
<td>PART 6</td>
<td>ENABLING CHANGE</td>
<td>56</td>
</tr>
<tr>
<td></td>
<td>6.1 Leadership and change</td>
<td>57</td>
</tr>
<tr>
<td></td>
<td>6.2 Internal change agents</td>
<td>62</td>
</tr>
<tr>
<td></td>
<td>6.3 Culture and change</td>
<td>68</td>
</tr>
<tr>
<td>PART 7</td>
<td>MANAGING CHANGE</td>
<td>72</td>
</tr>
<tr>
<td></td>
<td>7.1 Levels: individual, team, organisation</td>
<td>73</td>
</tr>
<tr>
<td></td>
<td>7.2 Response to change</td>
<td>80</td>
</tr>
<tr>
<td></td>
<td>7.3 Failure</td>
<td>84</td>
</tr>
<tr>
<td></td>
<td>7.4 Working with resistance</td>
<td>85</td>
</tr>
<tr>
<td></td>
<td>7.5 Critical success factors</td>
<td>89</td>
</tr>
<tr>
<td>PART 8</td>
<td>CONCLUSION</td>
<td>92</td>
</tr>
<tr>
<td></td>
<td>REFERENCES</td>
<td>95</td>
</tr>
</tbody>
</table>
Part 1

Introduction
Change has become an ever-present feature of our work environment, and the management of these continuing changes is a key challenge for all managers. Understandably, managers are reaching out for anything that will help them make sense of the nature and processes of change, and for tools and techniques that will help them manage in an ever-changing environment. As Burnes (2000) rightly claims ‘what almost everyone would like is a clear and practical change theory which explains what changes organisations need to make and how they should make them’. He goes on to explain that instead what is available is ‘a wide range of confusing and contradictory theories, approaches and recipes. Many of these are well thought out and grounded in both theory and practice; others, unfortunately, seem to be disconnected from either theory or reality’.

An additional difficulty posed by the change literature is that writers on change tend to reflect their particular discipline’s perspective on organisations and this sometimes leads to biases that can be confusing for the reader. Burnes (2000) makes the valid claim that ‘regardless of what their proponents may claim, we do not possess at present an approach to change that is theoretically holistic, universally applicable, and which can be practically applied’. McAuliffe (2000) argues therefore that ‘managers should be prepared to adopt a contingency approach choosing or developing the model to suit the particular situation’. Hence, the change agent’s quest should not be to ‘seek out an all-embracing theory but to understand the strengths and the weaknesses of each approach and the situations in which each can best be applied’, according to Burnes (2000).

Bennis (1969) distinguishes between theories of change, which focus on how organisations change and factors that produce change, and theories of changing, which focus on how change can be brought about and managed in organisations. This distinction highlights the role of the human agency in organisational change and innovation in terms of the contrast between planned and unplanned change. Planned change is consciously conceived and implemented by knowledgeable actors or agents, and how planned change may be effectively accomplished is explained in theories of changing. By contrast, unplanned change may or may not be driven by human choice. It is not purposefully conceived and may have positive and negative effects on the organisation’s direction. The implications of this distinction are conveyed by Poole and Van de Ven (2004) as follows: ‘The contrast between
planned and unplanned change focuses our attention on the degree to which change and innovation can be choreographed, scripted, or controlled. Theories of planned change specify ways to manage and control change processes. Theories of unplanned change, on the other hand, imply that change is to some degree a force in its own right, susceptible to channelling, but not necessarily to control or management.

The more difficult issue is the fact that planned and unplanned change cannot be so neatly separated and packaged. The reality is more complex than this, with planned change occurring almost always in the context of unplanned or emergent change. Indeed it could be said that it is the interplay between the planned and unplanned that shapes the future of any organisation. This is why it is useful for managers to have an understanding of how unplanned change processes unfold, as such knowledge will enable the manager to more effectively implement planned change, utilising, where possible, the unplanned change processes to do so. In health care environments change is ever present. Emerging technologies, new drug discoveries and evolving models of service delivery are all part of the unplanned change that is an everyday feature of this environment. Failure to take account of this emerging change when introducing a planned change can result in inappropriately rigid processes that fail to deliver the desired results.
Part 2

Change in the Irish health services
Health services throughout the world are undergoing significant reform and change that is driven by a changing legislative environment, advances in technology and pharmaceuticals, and increased public expectations. There are significant pressures for change arising from population changes also, with countries experiencing an increase in their elderly population and changing disease patterns.

In Ireland, the past decade has brought a continuous phase of change for our health services. The publication of two health strategies, *Shaping a Healthier Future* (Department of Health and Children, 1994), and the current national health strategy, *Quality and Fairness – A Health System for You* (Department of Health and Children, 2001), has provided the national strategic policy context for the development of the Irish health system over the past decade. The *Health Service Reform Programme*, published by the Department of Health and Children in June 2003, has the clear aim of modernising existing organisational structures and management practices within the Irish health services, to facilitate the implementation of the 2001 health strategy and to ultimately improve health services.

This reform process is the most significant since the establishment of a system of eight regional health boards empowered with responsibility for the provision of health and social services in their functional areas under the Health Act, 1970. The *Health Service Reform Programme* (2003) identified a number of system priorities which include a national focus on service delivery and executive management of the health system, reduced fragmentation of the current system, clear accountability, better budgeting and service planning arrangements, continuous quality improvement and external appraisal, robust information-gathering and analysis capability, and preservation of and building on the strengths of the existing system. The implementation of the reform programme has already resulted in significant structural and managerial changes in the health system and is now beginning to focus on culture, tasks and processes. Its full implementation will no doubt ensure that change is an everyday feature of the Irish health care landscape for the foreseeable future.

The *HSE Transformation Programme 2007-2010* sets out an ambitious programme of change in order to fulfil the HSE mission of enabling people to live healthier and more fulfilled lives. The vision for the HSE is that ‘Everybody will have easy access to high quality care and services that they have confidence in and staff are proud to provide.’
2.1 Health Services National Partnership Forum (HSNPF)

Partnership, as an approach to managing change in the Irish health system, has gained recognition in recent years. Partnership is set in the context of the prevailing national social partnership agreement and the provisions of the National Health Strategy - Quality and Fairness. It is given expression in the Health Services National Partnership Forum (HSNPF) Strategy and Service Plan.

The HSNPF was established in 1999 as a joint management and trade union steering group responsible for leading workplace partnership in the health services in Ireland. It was established under the terms of Partnership 2000, the national partnership agreement in place at the time. The current national partnership agreement, Towards 2016, pledges a renewed effort to strengthen partnership working in the context of the Health Services Reform Programme.

Partnership is a way of working, not just a once-off initiative. It requires commitment and leadership by all those involved. The HSNPF in its agreements and strategies set out general parameters requiring both a concerted and co-ordinated drive to improve responsiveness and flexibility in the delivery of health services and a dynamic response to staff aspirations for more fulfilling work and improved career paths.

When partnership is working effectively, the outcome is seen in a changed organisational climate conducive to better job satisfaction, increased motivation and commitment, and the provision of treatment, services and care that further benefit those for whom the service exists. Through successive national agreements, all health services staff, their representatives and managers, have agreed to participate in the modernisation agenda, whether through local service improvements or performance verification reports and site visits.

The partnership approach does not replace or substitute national or local industrial relations systems and procedures. However, as an effective partnership approach evolves and develops, it progressively reduces the traditional adversarial approach to industrial relations issues. Partnership creates and supports opportunities for an alternative dispute resolution process.

The HSNPF has recently published a document entitled Protocol on Handling Significant Changes through Partnership (HSNPF, 2006). The scope and strength of the statement of common interests, agreed by Forum members on 7 December 2005 underpins the new approach of the stakeholders to handling significant change and allows us to move forward with confidence, as partners, to address the following areas:
Guiding change in the Irish health system

- Development of better services for patients and service users.
- Creation of a better work environment.
- Increased value for money.
- Improvement of management/staff/trade union relationships.

The document sets out the following regarding the process of change in healthcare:

• The evidence suggests that a world-class health service can best be achieved through a ‘whole systems’, partnership approach that involves management, staff and their trade unions in all stages of the process.

• The process of involving staff and their representatives at an early stage in policy, planning and decision-making, is consistent with a world-class approach.

• The approach to change in the health service will be underwritten by this belief that the opportune outcomes and performance will be achieved through strong Trade Unions and strong Management working collaboratively.

(HSNPF, 2006: 24-25)

The main challenge that the partnership approach presents is that a genuinely participative approach takes time to achieve. In the current climate, many managers are focused on achieving quick wins or instant results and are therefore reluctant to engage in a participative and time-intensive process. For this reason, it can be difficult for the HSNPF to impact on some of the more significant issues in the Irish healthcare system (particularly those that have national significance where there is public and political pressure for rapid solutions to be found).

However, the HSNPF has and will no doubt continue to have a significant impact on how change is managed in the Irish healthcare system. The inclusive and participative nature of the partnership model is in keeping with best practice in change management and, as such, is more likely to result in successful and sustainable change than many of the approaches that preceded it.
Part 3

Theoretical change models
3.1 Planned models

It is impossible to think about change models without reference to the work of Kurt Lewin. Lewin was a prolific theorist, researcher and practitioner in interpersonal, group, intergroup and community relationships. In 1945 he founded and became the first director of the hugely influential Research Centre for Group Dynamics. His three stage model of change is probably the most widely known model. The three steps are: unfreezing the status quo, moving to a new state, and refreezing the new state to make it permanent. Lewin believes that systems are held in a steady state by equal and opposing forces. He identifies driving and restraining forces that influence the change process. Driving forces create pressure for change and include competitive pressures, new legislation, and innovation or creativity from within the organisation. Resisting or restraining forces impede change and include such things as existing custom and practice, organisation culture and climate, trade union agreements, etc. If the forces cancel each other out, the organisation is in a state of equilibrium. If forces pushing for change are stronger than forces maintaining the status quo, organisational change occurs.

Figure 3.1: Lewin’s force ‘field model’ of organisational change. Lewin, K. (1951).
Lewin suggested that changing behaviour should start by introducing information that shows discrepancies between desired behaviour and current behaviour. He considered communication to be a very important factor in successfully unfreezing the status quo. He also emphasises the importance of new cultures, structures and policies in refreezing behaviour.

<table>
<thead>
<tr>
<th>Unfreezing</th>
<th>Move</th>
<th>Refreeze</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disturb the equilibrium to lessen resistance to change and create the need for change</td>
<td>From old behaviours to new behaviours</td>
<td>Establish the new patterns of behaviour as the norm</td>
</tr>
</tbody>
</table>

Figure 3.2: Three-stage change process. Lewin, K. (1951).

Following on from Lewin’s work, many writers in the field of change management attempted to develop or complicate Lewin’s model by adding to its three stages. This spawned a recipe approach to the management of change, where the typical response to criticism of a model was to add further steps to it. Some examples of these stepwise models include Lippitt’s model and Cummings and Huse’s model.

Lippitt et al. (1958) developed a seven-phase model of planned change, as did Huse. Huse’s (1980) model was later modified by Cummings and Huse to become an eight-phase model. Huse’s model differs from other staged models in that it incorporates two feedback loops as shown in Figure 3.3. The first loop (1) relates to situations where the planned change has been enacted but, following a mid-point evaluation, its general thrust or specific action points are modified. An example might be organisation development (OD) intervention to reduce length of patient stay in an acute hospital setting. Midway through the process it becomes apparent that re-admission rates are rising. This might necessitate a change in focus where the OD intervention would need to be broadened to include the provision of increased support for patients post discharge.

The second feedback loop (loop 2) depicts the situation where a major development project has worked its way through to completion and the OD consultant moves on either to an entirely new organisation or to a new project within the host organisation. Huse’s model illustrates well the multi-phase process of OD work with organisations. This model distinguishes itself from the other planned models in that it shows some awareness of the complexity of organisations and acknowledges that unpredictable factors may impact on the implementation of the change plan.
Bullock and Batten (1985) attempted to address the problems in planned change models by developing an integrated four-phase model of planned change based on a review and synthesis of over 30 models of planned change. The model splits the change process into four phases:

- **Explanation** – importance of creating awareness of the need for change is emphasised.
- **Planning** – core activity of the model; uses an external consultant to work with employees to diagnose organisational problems and develop plans of action.
• **Action** – starts with implementation of the programme of change, evaluation and feedback of results to employees. It may involve modifications to the programme with further evaluation.

• **Integration** – changes are stabilised, i.e. become adopted as the new way that the organisation will function.

One of the criticisms of this model is that its final phase cannot be reached. Tushman and Nadler (1986), for example, suggest that it is impossible to stabilise change because it is a constant, ongoing process.

However, since the early 1980s, planned change models have come under increasing criticism. The main charges levelled against such models are as follows:

• They assume that organisations operate under stable conditions and can move from one stable state to another in a pre-planned manner. However, an increasing number of writers argue that in the turbulent and chaotic world in which we live, such assumptions are increasingly tenuous and that organisational change is more a continuous and open-ended process than a set of discrete and self-contained events.

• They emphasise incremental and small-scale change and are not applicable to situations which require rapid and radical transformational change.

• They ignore situations where more directive approaches may be required, such as when a crisis requiring rapid and major change does not allow scope for widespread involvement or consultation.

• They presume that common agreement can be reached, and that all the parties involved in a particular change project have a willingness and interest in implementing it. This presumption appears to ignore organisational conflict and politics, or at least assumes they can be easily identified and resolved.

Dunphy and Stace (1993) argue that different organisations face different situations and therefore must vary their change strategies accordingly. A contingency approach, while offering guidance, does not offer choice. Instead it replaces a ‘one best way for all’ with a ‘one best way for each’. Burnes argues that although Dunphy and Stace’s challenge to the ‘one best way’ school of thought is welcome, it is not without its shortcomings. ‘By adopting a contingency-style approach, they leave themselves open to the same sort of criticism that has been levelled at contingency theory itself: in particular, that organisations still have no choice – they must identify the key contingencies and adopt the prescribed approach.’ In contrast to Dunphy and Stace, Burnes argued that organisations can and do influence and change contingencies in order to make them more amenable to their preferred way
of operating. He further contends that organisations really do have genuine choice in both what they change and the process of change itself.

Pool and Van de Ven (2004), in discussing the distinction between episodic (one-off and time-limited) and continuous change (occurring over an extended period of time), draw correlations with other dichotomies such as incremental versus radical change, e.g. Tushman and Nadler (1986), Tushman and Romanelli (1985), continuous versus discontinuous change, e.g. Meyer, Goes, and Brooks (1993), first-order versus second-order change, e.g. Meyer et al. (1993) and competence-enhancing versus competence-destroying change, e.g. Abernathy and Clark (1985).

Burnes (1996) concludes that ‘the planned model is clearly one which is best suited to relatively stable and predictable situations where change can be driven from the top down. The emergent model, on the other hand, is one which is geared to fast-moving and unpredictable situations where it is impractical, if not impossible, to drive changes from the top’.

McAuliffe (2000) argues that many of the earlier change models ‘treat change as a linear process’ and that they suggest ‘if one follows the steps in the model this will lead to successful implementation’. These models originate from cybernetics and make assumptions of linearity and attaining stability or equilibrium. Implied in this is the understanding that prediction of outcomes should not present any problem. She claims that ‘such models are of limited value in helping us to change complex health care environments. Change is occurring at such a rapid pace in health care that it is unrealistic to expect stability or any kind of equilibrium to be reached’. She says ‘the more recent integrative models however take a non-linear approach to change and draw on a systems approach. Such models make use of positive and negative feedback loops and have a more realistic view of the difficulties of predicting outcomes. They recognise that equilibrium is unlikely and that unexpected behaviour patterns can emerge at any stage of the change process’.

3.2 Systems models

A system is a set of elements connected together which form a whole, thereby possessing properties of the whole rather than of its component parts (Checkland, 1981). Activity within a system is the result of the influence of one element on another. This influence is called feedback and can be positive (amplifying) or negative (balancing) in nature. Systems are not chains of linear cause-and-effect relationships but complex networks of interrelationships.

Systems are described as closed or open. Closed systems are completely autonomous and independent of what is going on around them. Open systems exchange materials, energy and information with their environment. Health care systems,
because of their interdependency with their environments in terms of inflow and outflow of patients, staff, supplies, etc. can be characterised as open systems.

In terms of understanding organisations, systems thinking suggests that issues, events, forces and incidents should not be viewed as isolated phenomena but seen as interconnected, interdependent components of a complex entity.

Applied to change management, systems theory highlights the following points.

- A system is made up of related and interdependent parts, so that any system must be viewed as a whole.
- A system cannot be considered in isolation from its environment.
- A system which is in equilibrium will change only if some type of energy is applied.
- Players within a system have a view of that system’s function and purpose and players' views may be very different from each other.

Leavitt et al. (1973) proposed a four-dimensional systems model of change (see Figure 3.4). They assert that while change efforts may focus upon one of the four subsystems, i.e. structure, technology, people, or task, intervention effects will be mutually dependent across all four subsystems in organisations. For example, an intervention to change an organisation's structure from a hierarchy of functional departments towards a matrix structure of semi-permanent and overlapping project teams will clearly have implications for the technology subsystem, the personnel employed and the methods of task allocation and job design. This in turn requires the development of IT systems to enable information to flow between central, regional and local levels.

As with most systems-type models, the overarching system is seen as consisting of multiple and interacting subsystems. This model highlights the complexity of change processes as change in one subsystem will almost inevitably result in knock-on effects of intended and unintended reactive changes in other dependent subsystems. It also draws attention to the fact that there may be several entry points for effecting change in a system. One variable can be deliberately changed to affect others.

Systems approaches to managing change can therefore take account of both planned and emergent change. The recognition that the introduction of a planned change in one part of the system is capable of producing an unplanned, emergent change (sometimes desirable and sometimes not) in another part of the system calls into question the value of a dichotomy between planned and emergent change. In systems thinking, linear cause and effect analysis is replaced by viewing patterns of interaction which mutually influence each other. Coghlan and McAuliffe (2003) illustrate this with a health care example (see Figure 3.5) below:

If we look at the health system, we can also see these patterns of interaction. A contentious issue for many health systems is waiting times for elective treatment. The ‘congestion’ in the health system, just as with the traffic congestion, cannot be accounted for solely by the increasing numbers of patients requiring treatment. The number of beds available and how these beds are currently utilised will influence the throughput, which in turn will influence waiting times. The range and complexity of diseases and procedures will also play a role, with more complex procedures generally requiring more time and resources. Seasonal influences play a part, with cold weather leading to increasing ill-health in the elderly, which in turn increases demand for beds. In some areas the tourist season means a substantial increase in the population and increased attendance at accident and emergency departments. This can place strain on regular services and result in the cancellation of elective cases in some instances. If this happens over a prolonged period, it may lead to a backlog which further lengthens the waiting lists. The retention of staff, which may be influenced by how ‘healthy’ the organisation is externally perceived to be, can also influence throughput and in turn waiting times. The general health of the population, the investment of resources in preventive strategies and primary care and the emergence of epidemics of disease are also factors that can influence demand over time. In such a complex system of interacting forces it is clear that addressing one issue may not be enough to solve the problem.

Figure 3.5: Systems thinking in health care. Coghlan, D. and McAuliffe, E. (2003).
‘Dynamic complexity’ refers to situations where a system is complex, not because of a lot of detail but because of multiple causes and effects over time (Senge, 1990). In situations of dynamic complexity, systems thinking provides a perspective of viewing and understanding how a system is held together by patterns of action and reaction, relationships, meanings and hidden rules and the role of time.

Mintzberg (1997) writes about hospitals as ‘disconnected’ systems or systems in which the subsystems remain largely disconnected from each other. He argues that some people manage down – straight into the operations in question, to the direct delivery of service. Other people manage up – dealing largely with the authorities above them and people outside of the system, while others manage out – to people not quite so formally committed to it. Mintzberg labels these worlds as care (inhabited by nurses), cure (inhabited by doctors), control (inhabited by managers) and community (inhabited by hospital board members). Because of the different perspectives of these four groups and the disconnectedness between their worlds, fragmentation occurs making it difficult to manage the delivery of a seamless service.

A more comprehensive and recent systems model is that developed by Burke and Litwin, as set out in Figure 3.6 overleaf.
The Burke-Litwin model provides an organisational framework that helps explain open systems theory in action and provides a way of thinking about planned organisation change (Burke and Litwin, 1992; Burke, 2002). Looking at the very top and bottom of the model, the external environment box serves as the input dimension to the organisation, while the individual and organisational performance box serves as the output dimension. The boxes in between provide the transformation dimensions. The arrows illustrate the recursive feedback loops. As Burke points out, to portray the model as close to reality as possible there would be arrows connecting all the boxes, but the figure does not do that in order to avoid making the diagram too daunting and messy. The model predicts cause so some directions are more important than others in planning and implementing organisational change.

The key to understanding the model is to compare the top half with the bottom half. The boxes in the top half – external environment, mission and strategy,
leadership and culture – are termed transformational factors, i.e. those that bring about change in the entire organisation. The boxes in the lower half – management practices, structure, systems, work unit climate, motivation, individual needs and values, task requirements – are termed transactional factors and are concerned with day-to-day operations, continuous improvement and evolutionary change. Change in transformational factors requires change leadership while change in transactional factors requires managers who focus on improvement.

Coghlan and McAuliffe adapt this model for use in the health care environment by clear and practical illustration of how each component of the model manifests itself in the health care environment (see Figure 3.7).

**Transformational factors**

The transformational factors are those that immediately respond to the external environment forces. Mission and strategy set the fundamental identity and direction of the organisation, are shaped and led by leaders and are enabled or inhibited by organisational culture.

**External Environment**

The external environment refers to those forces or changes taking place outside of the organisation that will influence organisational performance. The political climate for example has a direct impact on health systems, particularly in the time period immediately before an election when health moves up the political agenda. Political priorities, not health priorities may result in the postponement of a planned hospital closure, or may work to the organisation’s advantage if it finds itself moved up the list of priority projects for capital investment. Changing legislation is another external factor that can impact on health. For example, the Freedom of Information Act (1997) which allows a) members of the Public the right to obtain access to official information; b) the Information Commissioner to conduct reviews of decisions of Public Bodies in relation to requests for access to information, had a major impact on record-keeping and on the transparency of decision-making in health care organisations. The economic climate also has significant implications as it determines the size of the health budget which in turn influences levels of activity, numbers of posts that can be filled, etc. Public scandals have the potential to impact negatively on health organisations, a prime example being the hepatitis C caused by blood transfusions that lead to a dramatic fall in blood donations.

**Mission and Strategy**

Mission is the term used to describe the organisation’s raison d’etre, and answers the question ‘Why does this organisation exist?’ It refers to the present and clearly sets out the purpose of the organisation in a brief statement. The Department of Health and Children’s mission statement is:
‘In a partnership with the providers of health care, and in co-operation with other government departments, statutory and non-statutory bodies, to protect, promote and restore the well-being of the people by ensuring the health and personal social services are planned, managed and delivered to achieve measurable health and social gain and provide the optimum return on resources invested.’

This mission statement has a clear focus on the desired outputs and outcomes, whilst also acknowledging the various inputs that are required to achieve these outcomes. The use of the words ‘protect, promote and restore’ gives the clear message that the Department considers its remit to be broader than the treatment of disease and is focused on the provision of a health service not just a health care service, ie. not just restoring health but preventing ill-health arising in the first place. Significant words such as ‘co-operation’ and ‘measurable’ have been carefully chosen to indicate the change of emphasis in how the Department plans to do business.

Strategy follows from mission in that it sets out how the organisation or system will accomplish its mission over the next 3 – 5 years. Many strategic development initiatives begin not just with a mission but also a vision. Vision differs from mission in that it refers to the future and gives a picture of where the organisation would like to be. It usually contains phrases that suggest a challenge for the organisation. Common examples in health care include ‘to be a centre of excellence for the treatment of cancer’, ‘to provide the best care’, ‘to obtain satisfaction ratings greater than 95%’, ‘to be the best teaching hospital in the city’, etc. The Health Strategy (2001) sets out a very simple but powerful vision of

‘A Health System that:
• Supports and empowers you, your family and community to achieve your full health potential
• Is there when you need it, that is fair and that you can trust
• Encourages you to have your say, listens to you, ensures that your views are taken into account.’

Leadership

An important distinction is made between leaders and managers (Zaleznik, 1977; Carney, 1999; Fedoruk and Pincombe, 2000). Leaders provide vision, direction and energy towards change; they influence people by acting as a role model, by encouragement and praise, and they generate enthusiasm and excitement. Managers function more within a role. They work within the organisation’s objectives and use resources and information efficiently and effectively. While the two overlap, they are treated separately in this model. Leadership as a transformational factor refers to the behaviour of senior executives and managers throughout the organisation who provide direction and positive energy for change.
Exploring the difference between management and leadership at ward level, one would expect a managerially focused ward manager to be concerned about bed occupancy, throughput, staffing levels, expenditure and average lengths of stay. A ward manager with more leadership ability would probably be more concerned with benchmarking performance against other wards, with improving organisational culture and climate, and developing innovations that might also be utilised in other wards. A simplistic but relevant difference is that leaders will tend to be more outwardly focused, whereas managers tend to be more inwardly focused.

Culture

When people talk about what organisational culture is, they typically see it as ‘the way we do things around here’. When we read the popular literature about organisational culture we find it speaks of climate, becoming a learning organisation or building a team-based culture and hence it often focuses on human relations issues, such as communication and teamwork. These are essential elements of culture but are not the total picture. Organisational culture is a complex reality. We don’t see culture because it is too close to us. It only comes into consciousness when it is challenged, as when we go to another organisation or we have new members in our own organisation.

Schein (1999) describes three levels of culture which go from the visible to the invisible or tacit. The first level is the artefact level. These are the visible things – what we see, hear and feel as we hang around an organisation – the visible layout of the office, whether people work with their door open or closed, how people are dressed, how people treat one another, how meetings are conducted, how disagreements or conflicts are handled and so on. The difficulty about these visible artefacts is that they are hard to decipher. We don’t know why people behave this way or why things are this way. When we ask these questions we get the official answers, the answers that present the values that the organisation wants to impart. This is the second level of culture - organisational values. Open doors are a sign of open communication and teamwork, first name greetings are a sign of informality - sort of thing. Yet we know that this is not always true, that organisations, not unlike individuals, do not always live up to what they espouse, not necessarily due to any deliberate, nefarious or conspiratorial reason to deceive but for complex unknown hidden reasons. A more common answer to our question is more likely to be ‘I don’t know; they did things this way long before I joined and I got the message early on that this is how we do things here’. So we come to the third level of culture, that of shared tacit assumptions. These are the assumptions which have grown up in the organisation and which have made it successful. They are typically tacit or hidden because they have been passed from generation to generation within an organisation and organisation members don’t see them any more because they are taken for granted.
Therefore, culture is much deeper than open doors, plants and bright colours and mission statements and strategic plans. When we look at initiatives and why they haven’t worked or achieved their intended outcomes, the answer is likely to be that the initiatives violate some taken-for-granted assumptions that are embedded in the organisational psyche because they were successful in the past. That is the key. Because something is successful at some point in time it gets passed on as ‘the way we do things around here’. Schein sees culture as ‘the sum total of all the taken-for-granted assumptions that a group has learned through its history’ (1999a, p. 29). Therefore, an organisation’s culture is deep – it controls us more than we control it. It is broad and it is stable as it sets predictability and normality and hence changing it evokes anxiety and resistance.

How do we assess our organisation’s culture? This is difficult because we don’t know what to ask about our own culture. So questionnaires won’t tell us much about the organisation’s culture. As culture is concretely embedded it can be uncovered through reflecting on how concrete issues are handled. So a group could take a concrete problem or something it would like to improve or make work better. The group might find it useful to review the concept of culture existing at the three different levels of artefacts, espoused values and shared tacit assumptions. Then the group could work at identifying lots of artefacts which characterise the organisation. Then it could name the organisation’s espoused values as published in missions and policy statements. Finally, the group might compare the espoused values with the artefacts in those same areas.

**Transactional factors**

The transactional factors represent those organisational domains which have to do with day-to-day operations, incremental and evolutionary change.

**Structure**

Organisational structure refers to the way an organisation is structured in terms of functions (departments) and reporting relationships and is usually represented by an organisational chart consisting of boxes with job titles and solid or broken connecting lines. It is a useful representation of levels of authority, lines of responsibility, and pathways of communication within an organisation. Changing an organisation’s structure is a transactional rather than a transformational factor for change, because a structural change which involves moving people into different roles and changing titles will not necessarily create revolutionary change in an organisation. It could be likened to ‘moving deck-chairs on the Titanic’, i.e. it wouldn’t prevent the ship from sinking.

There has been a considerable amount of structural change in the health system in recent years. Closer examination of these changes show that structural change is more successful in achieving the aims of the organisation where it is accompanied by other changes. For example, the change in hospital
structures that introduced clinical directorates has met with varying degrees of success, but seems to be more successful where new personnel in the form of business managers/or nurse managers have been recruited, as they have been instrumental in introducing new ways of organising the work of the speciality. Also, the change from a programme structure to a ‘care group’ structure in many of the health boards has been difficult for some because of the lack of planning expertise within the new care group structures. The significant structural change in the health services for the eastern region has seen the introduction of the Eastern Regional Health Authority. This major structural change has been accompanied by a change in emphasis from ‘planning based on dictate’ to ‘planning based on comprehensive needs assessment’ and from overseeing through ‘budget control’ to overseeing through ‘regular monitoring and evaluation’. Without these changes the structural change alone would not have resulted in more integrated services in the eastern region.

Management practices
This box addresses how managers behave on a day-to-day basis to achieve organisation goals. We know that managers can behave in many different ways, from autocratic bullying at one extreme to opt out non-involvement at the other. Managers frequently present their leadership dilemmas in terms of a tension between the task of the group and their concern for the individuals in the group. They find, in some cases, that what benefits the group task may not be to the benefit of the individuals in the group, and vice versa. This is undoubtedly true in some instances. Managers have a responsibility for getting the job done and for looking after the welfare of their personnel as part of the description of their role.

Systems
Systems refer to the procedures that are in place that help to accomplish the tasks of the organisation. Patient information systems, service planning as a system of resource allocation and human resource management systems, such as personal development planning, are all examples of systems that facilitate the work of health care organisations. Although the introduction of a new system, such as performance appraisal, may gradually lead to change in an organisation, partly as a result of the knock-on effects on culture and possibly leadership, a new system introduced in isolation will not lead to immediate transformational change. An effective performance appraisal system should improve individual performance and may improve team performance, depending on how contribution to teamwork is appraised. This in turn may gradually lead to improved inter-team working and the organisation may slowly begin to shift from a ‘blame and shame’ culture to a ‘recognition and reward culture’.

Climate
Climate is the collective perceptions of people within the same team, department or work group: perceptions regarding how they are managed, how
clear they are about their manager’s expectations of them, how valued they believe their contributions are, how much support they receive, how involved in decision-making they feel, and how well they believe they work with other parts of the organisation.

Let us explore the climate of a psychology department that invited in an OD consultant to help build team morale, when it was raised at a department meeting that morale had fallen considerably in the past year. The OD facilitator through discussions with individual staff and sub-groups of the department surfaced a whole plethora of phrases that are relevant to diagnosing the climate of the department. A few examples…

‘Our head of department is never here, he’s always off to one committee or another’

‘Those psychiatrists are undermining our work by changing medication regimes during our clients’ therapy’

‘Community psychiatric nurses seem to be a law unto themselves taking direct referrals from general practitioners and running therapy groups and the community services general manager just stands back and says nothing’

‘We are inundated with referrals … nobody listens when we point out that the department needs more staff… and my colleagues spend so much time moaning about how awful the pressure is, that I find it impossible to achieve the goals I set myself’

‘I suppose you’ve (OD consultant) been sent to empower us … well we cannot change the situation because nobody tells us what is happening in this organisation’.

Clearly this climate is not conducive to a highly motivated team delivering an effective service. While this climate may be indicative of an organisational culture in which inter-group collaboration is not seen as important in the achievement of the organisation’s goals and some professions are given a higher value than others, it could equally be a localised climate that has been created in large part by the head of department’s leadership style. Improving the climate of this department will almost certainly improve the morale and productivity of its members. However, whether it results in significant change in the organisation as a whole is very much dependent on the factors at a higher level that may or may not be influencing the existing climate.

Task requirements and job skills
This refers to the degree to which there is congruence between the requirements of an individual’s job and that individual’s competencies to fulfil those requirements. For example, an organisation providing services for people
with disabilities has difficulty recruiting speech and language therapists and finds itself having to offer a head of department post to a therapist who has three years post-qualification experience in a general community speech and language therapist’s post. Whilst this person is an excellent therapist, she has no experience of disability services, nor has she any managerial training or expertise. She may well experience considerable stress in her new role because of these personal shortcomings. This could result not only in her individual performance being poor, but also the performance of the service as a whole.

The health service has recently shifted the focus of recruitment and interviewing practices from valuing knowledge of the health system and years and breadth of experience to valuing the competencies that are pertinent to the job to which the person is being recruited. Also, staff development tends to be more competency based than was previously the case.

**Individual needs and values**

Most behavioural scientists believe that enriched jobs enhance motivation. If individuals’ needs and values are congruent with the organisation’s values, this is likely to lead to a more motivated workforce and improved performance. In health systems it is argued that health professionals’ values are for the most part congruent with the health system’s goal of restoring health to patients. However, there may be mismatches in terms of the health professional and his/her organisational goals. For example, if a person thrives on risk-taking, he or she may not fit well within the risk-averse environment that is necessary to ensure the delivery of a consistently high-quality service. A person with high security needs may not perform well in an environment that is characterised by short-term contract and acting posts.

**Motivation**

Motivation is intrinsically linked with needs and values. Maslow’s work on motivation identifies a hierarchy of needs from basic biological needs to basic comfort through to self-actualisation. Hertzberg, famous for his two-factor theory, claimed that needs could be categorised as hygiene factors (pay, quality of supervision, fringe benefits, etc.) and motivator factors (autonomy, recognition, opportunity to fulfil personal goals, etc.). The absence of hygiene factors may result in dissatisfaction, whereas the presence of motivator factors is necessary for job satisfaction. Attending to the motivation of employees is therefore likely to involve finding appropriate ways of enriching their jobs through greater autonomy, recognition and involvement in decision-making. Some health services managers hold the view that it is difficult to motivate employees in the public service where there is very limited discretion on pay and reward. However, providing autonomy and involvement in decision-making is perhaps of equal, if not more importance to health professionals who, through their education and training, are led to expect that their opinions will be valued and that they will be expected to practice with a significant amount of autonomy.
Individual and organisational performance

Individual, group and organisational performance represent the output of the organisation. In the health services this is clearly the service delivered. Measurement of performance should therefore include throughput of patients, patient satisfaction, quality (as measured by health and social gain) and efficiency in terms of resource utilisation. In many instances performance measurement in health care is not yet sophisticated enough to take account of all of these measures and tends to focus for the most part on throughput.

A useful approach to measuring performance is the use of the balanced scorecard. The balanced scorecard is a customer-based planning and process improvement system aimed at focusing and driving an organisation’s change process (Chow et al. 1998). It focuses on translating strategy into a set of financial and non-financial performance measures, thus providing feedback to guide the improvement process. The details of the measures on the scorecard will vary from one organisation to another, but typically a scorecard would include at least the following four components:

- Customer perspective: How do customers see us?
- Internal business perspective: What do we need to excel on?
- Innovation and learning: Can we continue to improve and provide a better service?
- Financial perspective: How do our funders perceive our financial performance?

Chow et al. in exploring the application of the balanced scorecard to health care organisations interviewed top-level administrators, e.g. hospital CEOs and heads of laboratory services, who agreed that the scorecard was valuable in measuring performance in the health care sector. By involving staff at all levels and all disciplines in the scorecard development process, ‘the organisation can ensure full and open communication of needs, concerns and ideas, increased understanding of needed actions, as well as acceptance and dedication to a shared set of goals’ (p. 278).

Kaplan and Norton (1996), who developed the balanced scorecard, provide three guidelines to help organisations select appropriate measures:

- The performance measures selected should be positively related to degree of attainment of the related goal, i.e. the measure should increase as the attainment of the goal increases.

- Not all the performance measures should be focused on outcomes. Performance drivers should also be included as leading indicators, e.g. number of patients discharged could be an outcome measure and bed capacity might be an associated performance driver.
• The number of performance measures should not be too great as a multitude of measures can cause the organisation to lose its focus and become disillusioned if progress is not made on the majority of measures.

Figure 3.7: Burke-Litwin model application to healthcare. Coghlan, D. and McAuliffe, E. (2003.)
Part 4

Approaches to change
PART 4 APPROACHES TO CHANGE

4.1 Top down versus bottom up

The selection of a model to assist in understanding and planning change processes is to a large extent dictated by one’s underlying beliefs and assumptions about the nature of change. Those who promulgate a planned approach to change could be seen as supportive of implementing a top-down approach, i.e. change is something that is planned and imposed by senior management as only they have the ability to take an overview of the organisation and predict the future. The reality however is that the future is difficult to predict and hence change is difficult to control. Burnes (1996) argues that in response to the criticism of the planned model, a new approach to organisational change has been gaining ground in recent years. Although it has been given a number of different labels, such as continuous improvement or organisational learning, it is more often referred as the ‘emergent model of change’.

The emergent model tends to see change driven from the bottom up, i.e. by those lower down the organisation who are more familiar with the tasks and processes, rather than from the top down, and stresses that change is an open-ended and continuous process of adaptation to changing conditions and circumstances. Burnes also argues that change is a process of learning and not just a method of changing organisational structures and practices.

Dawson (1994) and Wilson (1992) both challenged the appropriateness of the planned model in an environment that is increasingly dynamic and uncertain. They argue that those who believe that organisational change can be successfully achieved through a pre-planned and centrally-directed process of ‘unfreezing’, ‘moving’ and ‘refreezing’ ignore the complex and dynamic nature of environmental and change processes, and do not address crucial issues such as the continuous need for employee flexibility and structural adaptation. The emergent model, on the other hand, stresses the developing and unpredictable nature of change. It views change as a process that unfolds through the interplay of multiple variables (context, culture, political processes and consultation) within an organisation.

To cope with this complexity, Pettigrew and Whipp (1991) proposed a model of strategic and operational change which involves five interrelated activities: environmental assessment, leading change, coherence, linking strategic and operational change, and developing human resources. They claim that ‘through undertaking these activities, organisations can cope with uncertainty by becoming open-learning systems, with strategy development and change emerging from the way the organisation, as a whole, acquires, interprets and processes information about its environment’.
The pace of external changes is so rapid and complex nowadays that it is impossible for a small number of senior managers to effectively identify, plan and implement the necessary organisational responses. Therefore, a major development in this respect, according to the supporters of the emergent model, is the move to adopt a ‘bottom-up’ rather than a ‘top-down’ approach to initiate and implement change. Also, organisations need to scan their environment regularly in order to adapt and respond to external as well as internal changes.

4.2 Mixed planned/emergent

Champagne (2002) claims that ‘according to management gurus, change is natural, inevitable and urgent and can be brought about by competent, effective leadership. Their formulas for competent change management are actually various blends of a number of change models. Overall, leaders have to be entrepreneurial, visionary, strategists, daring and even prepared for crisis and opportunity (strategic management model). They have to be forward-looking, and they must program and plan change with care and attention (rational model). They have to be charismatic, astute psychologists who can overcome the resistance of their troops (psychological model). They have to be human, participatory and empowering (organisational development model). They have to prefer flexible structures that can easily accommodate contingencies (structural contingency approach). Lastly, they have to be skilled negotiators who can build winning coalitions (political model)’.

Several writers have put forward a three-phase model of change (Beckhard and Harris 1987, Nadler, 1998). These are somewhat reminiscent of Lewin’s model comprising the current state, the transition state and the future state. Utilising these three phases of change, Nadler (1998) contends that it is useful to think of changes in terms of transitions, with the effective management of change involving the development of an understanding of the current state, having an image of the desired future state, and then moving the organisation towards that desired future state. Pettigrew and Whipp’s (1991, 1992) research demonstrates that the starting point for strategic focusing and change derives from an organisation’s skill in environmental assessment. Nadler (1998) states that effective organisations are those that appropriately position themselves in their environment. Bate’s (1999) framework of cultural change also highlights the need to assess the ‘fit’ or alignment between an organisation’s culture and the broader environment. The writings of these key experts in change all point toward the need to incorporate the planned alongside the emergent changes in any attempt to improve the organisation’s functioning.
4.3 Organisation Development

In their book *Changing Health Care Organisations* (2003), Coghlan and McAuliffe argue that there has been a developing awareness over the past 40 years or so that the process of change can be as important as its content. While content refers to what is done, process refers to how it is done. Lack of attention to process may mean that content suffers. OD is one of the few approaches that gives as much emphasis to process as content.

OD is an approach to planned organisational change. One of the earliest definitions was provided by Beckhard (1969:9), one of the founders of OD, as:

‘an effort (1) planned, (2) organisation-wide, (3) managed from the top, to (4) increase organisation effectiveness and health through (5) planned interventions in the organisation’s ‘processes’ using behavioural-science knowledge’.

French and Bell (1999:26) in their widely-used, standard OD textbook provide a more developed definition:

‘Organisation development is a long-term effort, led and supported by top management, to improve an organisation’s visioning, empowerment, learning and problem-solving processes, through an ongoing, collaborative management of organisational culture – with special emphasis on the culture of intact work teams and other team configurations – utilising the consultant-facilitator role and the use of theory and technology of applied behavioural science, including action research’.

The common elements in the many definitions focus on long-term organisational change, supported by top management, using behavioural science in a manner that enables the organisation to learn about itself and develop change skills (Hanson and Lubin, 1995). OD emphasises employee participation in diagnosing problems and in finding and implementing solutions to those problems and evaluating the results. For within an OD approach, everyone in the organisation who is affected by the change should have the opportunity to contribute to the continuous improvement process. It is because of the highly participative nature of OD that the approach has the ability to implement planned change while at the same time taking account of emergent change through listening to and encouraging active participation of all those involved in the change process. OD as an approach facilitates both top-down and bottom-up influences.

The following characteristics mark the distinctiveness of organisation development as an approach to managing change. These characteristics distinguish OD from a more general change management approach (Worren et al. 1999; Farias and Johnson, 2000).
• OD is a process for building healthy, high-performance organisations and improving and realising the full potential and self-renewing capabilities of organisations, groups and individuals. It is also an education-based strategy using a positive and constructive approach to successfully leading and managing change.

• OD is an interdisciplinary approach that draws primarily from the applied behavioural sciences (e.g. psychology and sociology) and uses understanding of business and the influence of technology on organisations.

• OD is values-driven and seeks to instil values and build cultures that bring out the best in organisations and people, and to encourage open, straightforward, helpful, ethical and increasingly self-directing behaviour.

• OD is a facilitative process that helps others discover and find solutions to their own issues.

• OD relies on a systems perspective of organisations that considers all aspects of an organisation and its interrelated parts, i.e. focuses on the ‘big picture’.

• OD is a data-driven, action research oriented approach that includes assessing reality and involving key stakeholders in evaluating results, exploring what is possible and planning further action.

• OD is a collaborative top-down, bottom-up process that recognises the importance of building the commitment and leadership of top-level decision-makers and involving all stakeholders in the change process.

• OD focuses on both process (how things are done) and content (what is done), recognising the importance of both.

• OD is often guided and facilitated by professionally trained change agents, both external and internal.

• OD is committed to the transfer of knowledge and skills, and to creating learning organisations where organisations and their members are continuously learning, sharing knowledge and improving the organisation.

• OD emphasises the importance of planned, lasting and sustained change, rather than the ‘quick fix’, while at the same time developing the organisation’s ability to adapt to changing times.

Coghlan and McAuliffe (2003) state that the Irish health services, having focused traditionally on changing structures and developing mission statements and strategy to create improvements in organisations, are slowly beginning to realise that process may deserve more attention in the change agenda (McAuliffe, Coghlan and Pathe, 2002; Coghlan, McAuliffe and Pathe, 2002-3).
Iles and Sutherland (2001) outline that the term organisational development (or OD) is interpreted in different ways by different practitioners; some seeing it as a comprehensive organisation-wide development programme with particular underpinning principles and common approaches, others using it more loosely to describe any development programme within an organisation which is designed to meet organisational objectives as well as personal ones. OD encompasses a huge area of management theory and practice and can be defined as: a set of behavioural science-based theories, values, strategies and techniques aimed at the planned change of organisational work settings for the purpose of enhancing individual development and improving organisational performance, through the alteration of organisational members’ on-the-job behaviours (Porras and Robertson, 1992). Organisational change that results from OD interventions – for example, improvement in organisational performance or enhancement of individual development – comes about because of changes in individual members’ work behaviour. In turn, behaviour is shaped by the setting within which a member is situated. OD interventions view different aspects of this setting as levers for change that are able to prompt desired behaviours. These include:

- Organising arrangements – goals, strategies, policies and procedures, administrative systems and reward systems.
- Social factors – culture, management style, interaction processes, informal patterns and networks, and individual attributes.
- Physical setting – space configuration, ambience and interior design.
- Technology – tools, equipment and machinery, IT, job design, work flow design, technical expertise, technical systems and procedures.

Depending on the type of organisational change sought, initiatives may be targeted directly at individuals in order to secure specific behaviour change, or they may be directed at a group or at organisational level in order to capitalise upon the leverage and moderating behavioural effects provided by membership of a social unit.

According to the Johns Hopkins University, typically, a unit could benefit from the assistance of organisation development:

- Before undertaking a change project that will impact many others.
- After receiving suggestion from audits, self-studies or external reviews.
- During a transition of leadership.
- When merging with or splitting from another unit.
- During periods of rapid growth in scope, funding or size.
• As you consider what is next for your organisation in three to five years.
• When concerned about ongoing departures and turnover.
• If conflicts are excessive and interfering with getting the work done.
• When frustration is mounting from too many problems, demands and challenges.
• When clients, customers, leaders or other stakeholders are dissatisfied with results.
• When the same problem persists despite changes in individual leaders, faculty or staff.
• If your group seems to lack a shared set of goals or when people are confused about the direction of the unit.

4.4 Change typologies

The nature and type of change, as well as the time available to make that change will inevitably influence the approach that an organisation adopts. Ackerman (1997) has distinguished between three types of change: developmental, transitional and transformational.

• Developmental change may be either planned or emergent; it is first order or incremental. It is change that enhances or corrects existing aspects of an organisation, often focusing on the improvement of a skill or change. Such a change lends itself to a local problem-solving approach.

• Transitional change seeks to achieve a known desired state that is different from the existing one. It is episodic, planned and second order, or radical. The model of transitional change is the basis of much of the organisational change literature (Kanter, Beckhard and Harris, and Nadler and Tushman). It has its foundations in Lewin’s work, conceptualising change in his three-stage process (as previously outlined).

• Transformational change is radical or second order in nature. It requires a shift in assumptions made by the organisation and its members. Transformation can result in an organisation that differs significantly in terms of structure, processes, culture and strategy. It may, therefore, result in the creation of an organisation that operates in developmental mode – one that continuously learns, adapts and improves.
4.5 Matching strategy to approach

The approach and strategy to change will be very much dependent on whether the change is developmental, transitional or transformational. Some of the most commonly adopted strategies are presented below, drawing from Coghlan and McAuliffe (2003:21) and supplemented by other relevant authors in the area:

- **Training** is an activity in which many organisations invest considerable resources. What can typically happen is that the focus is on the individual and the organisation does not change. Organisational structures, culture and processes may present obstacles to the newly trained individual as he/she tries to change his/her way of working. While training could be part of OD, the OD approach typically works at integrating training into planned organisational change.

- **Management development** is really ‘manager development’ and its purpose is to update the skills, capabilities and capacity of managers. These do not necessarily change the organisation unless they are linked to other elements of how the organisation works and what changes are planned. Managers’ performance is not only influenced by managers’ skills and capabilities but will also be strongly influenced by the reward system, the culture, etc.

- **Total Quality Management (TQM)** (also referred to as Continuous Quality Improvement or CQI) refers to a management process directed at establishing organised continuous improvement activities involving everyone in an organisation in a totally integrated effort toward improving performance at every level (Almaraz, 1994). Originally taken up in Japan, it proved popular in the West in the early 1990s. The four general theses underpinning TQM (Berwick et al., 1992; Hackman et al., 1995) are:

  1. Organisational success relies on every department meeting the needs of those it serves (customers) and many of these customers will be internal to the organisation.

  2. Quality is an *effect* caused by the processes of production in which the causal systems are complex but understandable.

  3. Most human beings engaged in work are intrinsically motivated to try hard and to do well.

  4. Simple statistical methods linked with careful collection and analysis of data on work processes can yield powerful insights into the causes of problems within those work processes.
Joss and Kogan’s (1995) evaluation of TQM in the UK National Health Service (NHS) found little evidence of staff empowerment or changes in health status. They concluded that implementation was piecemeal and rarely focused on core organisational processes (i.e. clinical practice) of the NHS, concentrating instead on peripheral and administrative activities. These findings may reflect the reluctance of medical staff to engage in TQM efforts: Berwick et al. (1992) assert that where TQM has been tried in hospitals so far doctors are often not effective on quality improvement teams. They arrive late or not at all to the meetings, they dominate when they are present, and they sometimes leap to solutions before the team has done its proper diagnostic work on the process.

- **Business Process Reengineering** (Talwar, 1994:41) explains ‘while there may be some debate about who originated the concept, the term ‘reengineering’ was first introduced into common business usage in a seminal Harvard Business Review article: *Reengineering Work: Don’t Automate, Obliterate*. The article’s author was Michael Hammer, a former computer science professor at the Massachusetts Institute of Technology. Hammer then went on to develop the concept further with James Champy in a book entitled *Reengineering the Corporation*. They provided the following definition:

‘Reengineering is the fundamental rethinking and redesign of business processes to achieve dramatic improvements in critical, contemporary measures of performance, such as cost, quality, service, and speed’.

Kohn (1994) informs us that BPR ‘is a management philosophy capturing attention in health care. It combines some new, old, and recycled management philosophies, and, more often than not, is yielding positive results. BPR’s emphasis is on the streamlining of cross-functional processes to significantly reduce time and/or cost, increase revenue, improve quality and service, and reduce risk. Therefore, it has many applications in health care’. Coghlan and McAuliffe (2003) argue that BPR claims to be a radical approach to organisational change and builds on OD in the sense that it encourages managers to rethink what they do and how they do it in order to achieve greater efficiency and effectiveness. It differs from OD in that it tends to focus on short-term outcomes and often ignores the difficult concepts of power, politics and culture. Buchanan (1997:69), attempting to reengineer an operating theatre, identified several problems with the approach including the difficulties of taking account of the different political agendas of the professions involved and the lack of precision in the approach allowing scope for political manoeuvring. He noted that BPR appears ‘insensitive to organisational history, context and politics, and as such sits outside the mainstream of organisational development theory and intervention where contextual sensitivity is generally regarded as a prerequisite for change’.
E-health, an IT project, has been introduced into the Canadian health system as a potential solution for the most publicised symptoms of the many problems health care in Canada is facing, such as excessive waiting times for patients, lack of access, high cost of delivery and medical errors. The E-Health project has been implemented through the application of BPR principles. Bliemel and Hassanein (2004) propose that ‘a BPR perspective is beneficial when determining how to proceed with improvement projects in the health care sector, as many of these endeavours affect multiple parties and the processes managed between them. The BPR perspective of health care reform provides insights into the processes that are facilitated by technology and examines what changes are required for processes within the health care system to exploit the full benefits of adopting 21st century information systems and management principles’. In the same way Buchanan, Bliemel and Hassanein have identified several key obstacles that hinder the implementation of e-health using BPR principles, such as ‘privacy, standardisation, collaboration and political issues’. But they claim that ‘while there are many differences between the Canadian health care system and others, many of the problems, issues and solutions are similar – as such, the approach to health care reform using BPR principles … can be utilised in other health care systems as well.’ They expect that ‘the area of reengineering in health care will grow substantially, both practically and academically in years to come’.

Carmichael (1994) defends that BPR ‘may be the strong medicine required to achieve dramatic productivity improvement without jeopardising the quality and scope of core health care services’. But Iles and Sutherland look at the use of BPR in health care differently. They found that ‘the purely top-down, imposed approach of reengineering has not proved successful in a professionalized organisation such as the National Health Service (NHS), UK. Findings suggest that NHS initiatives attempting to apply redesign techniques need both the bottom-up commitment and initiative of clinicians and also top-down commitment from senior managers if they are to succeed. Senior leadership is key to ensuring smaller improvements are consistent with overall direction. It is also vital for ensuring that redesign initiatives are integrated with mainstream organisational processes and objectives; while it is felt to be extremely helpful to have a dedicated change team who can maintain momentum and provide a pool of expertise, it is important that they are not isolated (and dismissed) as a ‘special project’. There is a consensus that redesign takes time, and that hopes of ‘overnight’ transformation are misplaced, although identifying some early successes helps gain interest and acceptance. Individuals and organisations need time to learn new ways of thinking, to reflect and to implement, and both clinical and managerial staff need dedicated time set aside.’
• **Teambuilding** typically means developing team leaders. Developing team leaders may not have its desired outcomes unless staff are helped to work as team members. Another pitfall is that a focus on teams may be undermined by a focus on the individual in the reward or promotion system. If rewards are based on individual performance, this may create a tendency for team members to compete with rather than cooperate with each other.

• **Performance management** is a system that aims to improve organisational performance by improving individuals’ performance. This is achieved by setting goals and targets and measuring progress on the achievement of these goals. Performance is measured according to a predetermined set of performance indicators. This can create difficulties as performance tends to improve in the areas for which indicators have been set, but this may have a knock-on negative effect on performance in other areas. Such a system can also create difficulties for collaborative working if rewards are based on individuals’ performance, as is usually the case.

• **Action learning** is an approach to the development of people in organisations which uses the task as the vehicle for learning. The learning process is based on a cycle of planning, action, reflection and evaluation. Participants work in teams or learning sets on real problems. The problems for the most part tend to be an individual’s problem or a team’s problems but rarely the organisational problems. As an approach it therefore has limited ability to impact on the total organisation.

All of the approaches outlined above have the potential to improve organisational functioning, particularly if utilised as part of an organisation-wide approach to change. The problem is that too often such approaches are implemented in isolation with little account of the potential effects of other processes in the organisation. What is important to note is that none of these interventions focus on the whole system. The overall point is that OD is system-oriented, based on the premise that organisations are complex and held together by interconnected and interdependent elements. A change in one can have a knock-on effect on other elements (whether intended or unintended). While an OD approach may utilise management development, training and teambuilding, etc., these of themselves are not OD as they don’t have a total system perspective.
Part 5

Tools for change
PART 5  TOOLS FOR CHANGE

The sheer size and scope of literature around change management tools and models that has been developed over the last 50 years or so can make it very hard for managers and practitioners to find their way around. The myriad of tools can be classified in a number of different ways. Here we have chosen to classify them into three groupings based on our understanding of their function:

1. Tools that assist in understanding organisational problems.
2. Tools that assist us assess capacity for change.
3. Tools that assist in the action of achieving change.

The complexity and size of the health services in Ireland mean that managers and professionals are always working on several levels at once. They are dealing with a range of pressures from the centre, for example, and also with immediate local demands. Hence, they are working with multiple priorities competing for time. Many feel a need to bring together disconnected external initiatives and internal requirements into one coherent approach. The concepts below range in scope from comprehensive methodologies to single tools. However, they all provide insight into potential ways of understanding and dealing with these multiple priorities and pressures.
5.1 Tools that assist in understanding organisational problems

Weisbord’s six-box organisational model

Weisbord suggested in 1976 that there were six key areas in which ‘things must go right’ if an organisation was to be successful. These are depicted in Figure 5.1. The model provides a diagnostic tool for identifying the key areas.

Figure 5.1: Weisbord’s six-box organisational model. Adapted from Iles, V. and Sutherland, K. (2001), 26.

This is a useful model if one is undertaking a root-and-branch review of the organisation or in establishing a new service or organisation. It is however more difficult to employ in an organisation where there are entrenched professional positions regarding ownership of tasks and where new rewards and incentives cannot be easily introduced.
**7-S model**

Some years later Waterman, Peters and Philips (1980), working for the US management consultancy McKinsey, developed a rather similar approach. They suggested that there were seven aspects of an organisation that needed to harmonise with each other and to point in the same direction like the needles of seven compasses. If each aspect supports the others, then the organisation can be said to be ‘organised’. As each of these aspects can be titled with a word beginning with ‘S’, this list or web has become known as the 7-S model (see Figure 5.2). The constituent parts of the 7-S model are:

1. **Strategy**: plan a course of action leading to the allocation of an organisation’s finite resources to reach identified goals.

2. **Structure**: salient features of the organisational chart (e.g. degree of hierarchy, presence of internal market, extent of centralisation/decentralisation) and interconnections within the organisation.

3. **Systems**: procedures and routine processes, including how information moves around the organisation.

4. **Staff**: personnel categories within the organisation, e.g. nurses, doctors, technicians.

5. **Style**: characterisation of how key managers behave in order to achieve the organisation’s goals.

6. **Shared values**: the significant meanings or guiding concepts that an organisation imbibes in its members.

7. **Skills**: distinctive capabilities of key personnel and the organisation as a whole.
The 7-S model can be used in two ways:

1. Strengths and weaknesses of an organisation can be identified by considering the links between each of the Ss. No S is a strength or a weakness in its own right; it is only its degree of support, or otherwise, for the other Ss which is relevant. Any Ss which harmonise with all the other Ss can be thought of as strengths and any dissonances as weaknesses.

2. The model highlights how a change made in any one of the Ss will have an impact on all of the others. Thus, if a planned change is to be effective, then changes in one S must be accompanied by complementary changes in the others.
PESTELI

This is a checklist for analysing the environment of an organisation or its subunit. Initially, the acronym PEST was devised, which stands for:

- **Political factors**: both big and small ‘p’ political forces and influences that may affect the performance of, or the options open to the organisation.
- **Economic influences**: What economic pressures are we facing? What are the financial resources available within the economy to justify the changes?
- **Sociological trends**: What demographic changes, trends of how people live, work and think could affect the whole of the institution or a particular faculty or department?
- **Technological innovations**: What are the new approaches to doing new and old things, and tackling new and old problems; these do not necessarily involve technical equipment – they can be novel ways of thinking and organising.

More recently the list has been expanded to PESTELI, and now includes:

- **Ecological factors**: definition of the wider ecological system of which the organisation is a part and consideration of how the organisation interacts with it.
- **Legislative requirements**: originally included under ‘political’, relevant legislation now requires a heading of its own.
- **Industry analysis**: a review of the attractiveness of the industry of which the organisation forms a part.

Like the 7-S model, this checklist can be used to analyse which factors in the environment are helpful to the organisation, and which may impede progress to the organisation’s aims. From here, work can commence on how the organisation...
Guiding change in the Irish health system

could respond to these forces. It is only if this second stage is undertaken that PEST or PESTELI becomes useful. Unfortunately, many organisations make the mistake of thinking that once the analysis is done, the work is complete. But too often included as a stand-alone section in reports, and not linked to any implications for organisational action, nor to the internal analysis (7-S or equivalent), this tool for the analysis of the external environment frequently may not yield a return for the investment of time made to undertake it. This is not an indictment of the tool, rather an indication that its potential is frequently misunderstood.

There is a danger, common to all checklists, such as the ones discussed here, that once an entry has been made under each of the headings it is deemed complete, regardless of whether or not this list reflects the complexity of the reality. Another common error in implementation is that the ‘boxes’ are completed without reference to the aims of the organisation or to the change programme. This can lead to considerable expenditure of time and energy for little benefit.

Five whys

The five whys is a simple tool that can help managers resist the temptation to deal with the symptoms rather than causes. It addresses single-problem events rather than broad organisational issues and attempts to analyse a problem or issue by asking a series of ‘Why (did this happen)?’ questions.

If a problem occurs, the first ‘Why?’ question is asked: ‘Why did this happen?’ A number of answers may be found and for each of these the next ‘Why?’ is asked: ‘Why is that?’ The whole process is repeated until five consecutive ‘Why’s’ have been asked and answered. In most instances it has been found that five repeated ‘Why’s’ are necessary to get to the real root cause of the problem.

Root cause analysis

Most problems which arise within an organisational context have multiple approaches to resolution. These different approaches generally require different levels of resource expenditure to execute. And, due to the immediacy which exists in most organisational situations there is a tendency to opt for the solution which is the most expedient in terms of dealing with the situation. In doing this, the tendency is generally to treat the symptom rather than the underlying fundamental problem that is actually responsible for the situation occurring. Yet, in taking the most expeditious approach and dealing with the symptom, rather than the cause, what is generally ensured is that the situation will, in time, return and need to be dealt with again. Root cause analysis, like the five whys, is a tool that attempts to identify the root cause of the problem, i.e. finding the real cause of the problem and dealing with it rather than simply continuing to deal with the symptoms. To find root causes there is really only one question that’s relevant, ‘What can we learn from this situation?’ Research has repeatedly proven that unwanted situations
within organisations are about 95% related to process problems and only 5% related to personnel problems. Yet, most organisations spend far more time looking for culprits than causes, and because of this misdirected effort, seldom really gain the benefit they could gain from understanding the foundation of the unwanted situation. Root cause analysis has proved a useful tool in risk management and the identification of significant risks in health care environments.

5.2 Tools that assist in assessing capacity for change

SWOT analysis

SWOT is an acronym for examining an organisation’s strengths, weaknesses, opportunities and threats, and using the result to identify priorities for action (Ansoff, 1965). The main principle underlying SWOT (See Figure 5.4) is that internal and external factors must be considered simultaneously when identifying aspects of an organisation that need to be changed. Strengths and weaknesses are internal to the organisation; opportunities and threats are external.

![SWOT analysis diagram]

**Figure 5.4: Tool for SWOT analysis. Ansoff, H.I. (1965).**

Many managers and health professionals will have experience of working with this framework. A team or other subunit of an organisation writes down its mission or purpose. Keeping this mission in mind, they then identify all their strengths and weaknesses, preferably using a checklist such as the 7-S model. They do the same for opportunities and threats, using a checklist for the external environment such as PESTELI. On its own this information is rarely helpful or usable and must be considered further. This requires the asking of further questions about each of the factors listed under the four headings.
For **strengths and weaknesses**, the questions asked are:

1. What are the consequences of this? Do they help or hinder us in achieving our mission/vision? If the factor does genuinely help the achievement of the mission (and only if the positive impact on the mission is convincing) then indeed it is a strength. Similarly, if, but only if, it hinders achievement of the mission, it is a weakness.

2. What are the causes of this strength (or weakness)?

For **opportunities and threats**, the questions are slightly different.

1. What impact is this likely to have on us? Will it help or hinder us in achieving our mission/vision? Again, only if the opportunity helps the team achieve the mission can it be considered an opportunity. Even if it causes the world to be a nicer place, but fails to impact on the team’s ability to achieve its mission, it will not be an opportunity for these purposes.

2. What must we do to respond to this opportunity or threat?

The analyst now reflects on the mission/vision and all four components, paying particular attention to the causes of the strengths and weaknesses, and to the responses required to the opportunities and threats, and links together common threats into a set of priorities for the team to address.

**Force-field analysis**

According to Cork (2005), with any planned change some preparatory work needs to be undertaken to predict the relative success of that change. It has been suggested that a number of techniques to predict success could be appropriate in practice, one of which is force-field analysis, based on the work of Kurt Lewin (1951) (see Figure 3.1). He proposes that when implementing any change there are a number of factors that help to achieve change (drivers) as well as factors that may impede change (restrainers). An example of a driver may be to improve staff or patient conditions. Conversely, a restraining factor could be unwillingness to change, or low staff morale. Lewin (1951) argues that it is easier to remove resisting forces than it is to generate more driving forces, as the resisting forces will only increase in strength to compensate. Using this format, it is possible to conceptualise the drivers and restrainers and to consider ways in which these can be diminished in a given situation.

It is a simple and quite widely used tool for visualising the various forces and identifying actions to support the implementation of change. The following assertions apply:
Increasing the driving forces results in an increase in the resisting forces. Thus, the current equilibrium is maintained but under increased tension.

Reducing resisting forces is preferable because it allows movement in the desired direction without increasing tension.

Group norms are an important force in resisting and shaping organisational change.

A force-field analysis usually involves the development of a visual diagram. The driving forces and resisting forces are identified and then indicated pictorially with lines of differing strengths indicating the relative importance of each aspect.

For the model to be of use, the forces need to be identified perceptively, rigorously and objectively, and the means identified of addressing the resisting forces need to be creative.

Many practising managers will be able to reflect on occasions in their own experience when they have aimed to increase the driving forces, rather than reducing the resisting ones, and have increased the resistance and the tension as a result. Other change management authors have equally developed models and tools which analyse forces, e.g. ‘sources and potency of forces’ and ‘readiness and capability’.

Source and potency of forces

In their book *Organisational Transitions: Managing Complex Change* (1987), Beckhard and Harris describe and illustrate two techniques for analysing relevant sources of energy. They analyse respectively the ‘sources and potency of forces for change’, and the ‘readiness and capability’ of individuals and groups to enact change.

First, the nature of the change demanded must be specified, using tools as described above. Then all the forces for change, both inside the organisation and external to it, are listed along one axis of a grid. On the other axis, the potency of the forces is indicated, as high, medium or low. The grid is useful for clarifying the underlying forces for change. On occasion, as Beckhard and Harris point out, the energy for change emanates from one particular senior manager, rather than from a variety of environmental sources such as demographic change and new technologies. They observe that this does not invalidate the change objectives but clarifies where the energy will have to come from in the ensuing change programme.

Whereas Lewin’s analysis is used to diagnose and plan interventions, this is more useful as a vehicle for discussion among key opinion-formers at an early point in the change process, to ensure that everybody is aware of the need for change.
Guiding change in the Irish health system

### Potency of forces

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>External forces</strong></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>New legislation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Internal forces</strong></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Staff opposition</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor IT skills</td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

Figure 5.5: Source and potency of forces. Adapted from Beckhard, R. and Harris, R. (1987).

### Readiness and capability

Early on in the change process, managers need to identify which specific groups and individuals will be required to support the change if the change is to be successful. When they have done so, they can then determine the readiness and capability of these individuals and groups to enact the roles required of them in the change process. Understanding the readiness involves analysing attitudes: willingness, motives and aims. Capability is determined by whether they have the power, the influence and the authority to allocate resources, and the appropriate information and skills. Beckhard and Harris (1987:63) have developed a Readiness-Capability Assessment Chart which enables the user to list individuals or groups who are critical to the change effort, and rank them (high, medium or low) according to their readiness and capability with respect to change.

In health care organisations power is derived from a number of different sources and is not as easy to identify as in other industries. In any change management process the location of power and the use to which it will be put need to be known by those attempting to lead the process and this tool is, among other things, a means of finding out its location.

Any change agent or senior manager in a health care setting will intuitively undertake an analysis of this sort. This chart helps bring it into the open, permits assumptions to be tested and information to be shared, and thus increases the validity of the information available to the change agent.

<table>
<thead>
<tr>
<th></th>
<th>Readiness to change</th>
<th>Capability for change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low</td>
<td>Medium</td>
</tr>
<tr>
<td><strong>Staff nurses</strong></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td><strong>General manager</strong></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

Figure 5.6: Assessment of capability and readiness to change. Adapted from Beckhard, R. and Harris, R. (1987).
Commitment, enrolment and compliance

Where a change must be implemented from the outside, so to speak, that is, when it has not been defined as necessary by the people involved, then it is unlikely to succeed (yield the full results of which people have ambitions) unless some of those involved are in favour of it. Several observers have suggested however that not everyone needs to support a change, and that not everybody needs to support it to the same extent.

Senge (1990) talks of the difference between commitment, enrolment and compliance, suggesting that while it is more pleasant (and reassuring) to have considerable commitment, it is not necessary for everyone to be as fully signed-up as this. There exist a number of positions along a continuum, along which players may position themselves in response to proposed action and change.

Senge suggests analysing what level of support is required from each of the players and directing energy to achieve that, rather than at trying to persuade everybody to ‘commit’.

5.3 Tools that assist in the action of achieving change

Content, context and process model

This model of strategic change was originally developed by Pettigrew and Whipp (1991) as a means of generating insight into why some private sector organisations were better able than others to manage strategic change and improve their competitive performance. The model was based on empirical case studies.

It is a reminder that change takes place in a historical, cultural, economic and political context. The original model suggests there are five interrelated factors that are important in shaping performance.

1. Environmental assessment.
2. Human resources as assets.
3. Linking strategic and operational change.
4. Leading change.
5. Overall coherence.

Like the other models in this group, this stresses the importance of interacting components. It suggests that successful change is a result of the interaction between the content or what of change (objectives, purpose and goals); the process or how of change (implementation); and the organisational context of change (the internal and external environment).
**Hard systems methodology**

Hard systems methodology promotes a sequential, staged approach to change. The stages are numbered and the sequence provides the orderliness, characteristic to this methodology. Reiteration and going back to a previous stage is possible if environmental influences invalidate certain assumptions and if subsequent work has introduced an element of uncertainty, which hadn’t been taken into account in the beginning.

<table>
<thead>
<tr>
<th>Stages</th>
<th>Questions to answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Define the problem</td>
<td>What needs to change?</td>
</tr>
<tr>
<td>Analyse existing situation and relevant systems</td>
<td>Where are we now?</td>
</tr>
<tr>
<td>Identify objectives and constraints</td>
<td>Where would we like to be?</td>
</tr>
<tr>
<td>Generate ways of meeting objectives</td>
<td>How would we get there?</td>
</tr>
<tr>
<td>Formulate measures of performance</td>
<td>How will we know when we have achieved change?</td>
</tr>
<tr>
<td>Develop options</td>
<td>What would the options be like?</td>
</tr>
<tr>
<td>Test these options</td>
<td>Are these feasible/achievable/within budget?</td>
</tr>
<tr>
<td>Choose to implement the most relevant option</td>
<td>Choice (politics, power, equity)</td>
</tr>
<tr>
<td>Implement option</td>
<td>Implementation brings about other problems to be solved</td>
</tr>
</tbody>
</table>

**Figure 5.7: Stages in hard systems methodology. Iles, V. and Sutherland, K. (2001).**

**Soft systems methodology (SSM)**

Developed by Peter Checkland (1981) at Lancaster University, this methodology arose out of attempts to apply systems engineering principles (‘hard’ systems theory) to business problems. When applying systems engineering to what Checkland called ‘human activity systems’ (people working together to achieve something), Checkland found a number of problems:

- Organisation goals were matters of controversy. (Organisational goals, set by top management, were assumed to be embraced by all members of the organisation, but this is usually not the case.)

- Formal methods usually begin with a problem statement. (Checkland found that fixing the problem too early made investigators unlikely to see different, possibly more basic, problems.)
• The method itself restricted what could be found out. (If we expect the organisation to be describable by the interaction among a number of clearly bounded subsystems, then that will happen – we will see in the organisation a reflection of our methods.)

To overcome these problems Checkland eventually proposed the soft systems methodology, and based it on the following tenets:

• Problems do not have an existence that is independent of the people who perceive them.
• Solutions are what people perceive to be solutions.
• People perceive problems or situations differently because they have different beliefs about what the situation is and what it should be.
• Problems are often linked to ‘messes’ (Ackoff, 1974).
• The analyst, researcher, consultant or manager trying to solve the problem is an integral part of it.

The stages of the soft systems approach:

1. **Problem expression.** People who perceive there to be a problem cannot be certain as to what it is and should keep an open mind until the analysis is done. Being unsystematic at this stage is considered to be a virtue. Analogies and models from other fields (ranging from politics to engineering and culture) can be looked at. The usual creative techniques such as brainstorming can be used at this stage, as well as checklists.

2. **The situation analysed.** This involves developing a rich picture, comprising of all the elements that people think are involved in the problem (their purposes, desires, fears) usually by using think-bubbles, just like in cartoons. Rich pictures include more environmental detail than most diagrams (human activities, like processes, cross-organisational boundaries), and they show how and whose interests agree or conflict. When analysed, issues and key tasks emerge.

3. **Relevant systems and root definitions.** The issues and key tasks, which surfaced in the rich picture, become the basis for defining relevant systems. It has been described like a very brief mission statement, the minimum we can agree on, but it must describe our real activity. The root definition defines what is agreed and what is still up for discussion, and that many important (but not yet agreed) things might not be mentioned. ‘We need to be sure that so far everyone is still with us.’ Achieving a truly agreed root definition (at least for the time being) is probably the most beneficial part of SSM.
4. **Conceptual model.** At this stage, those involved model their ‘ideal’ system to do the job. Criteria for choosing the best one is agreed. As criteria, Checkland suggests five Es: efficacy (will it work at all?), efficiency (will it work with minimum resources?), effectiveness (does it contribute to the enterprise?), ethicality (is it moral?) and elegance (is it beautiful?).

5. **Comparison of steps 2 and 4.** The conceptual model is then used for comparison with the current system. What is stopping us do things the ‘ideal’ way? Why do we do things the way we do them? How do we measure up to the five Es criteria? Did the results confirm our intuition? – using the knowledge gained there, to map the effects of the proposed changes on stakeholders.

6. **Debate of feasible and desirable changes.** Building on step 5 through debate, an agenda, comprising of feasible and desirable changes can be put together, and opinions about the root problems can be changed.

7. **Action.** Finally, the agreed changes need to be implemented. Checkland sees implementation as a new human activity, which reveals new compromises, thus bringing us to square 1 – the problem expression. It is unlikely that the final outcome will match the agreed change exactly. SSM has a philosophy of continual improvement, but the hope is that some of the issues agreed in the early stages will not resurface, that discussions arising during implementation will be more focussed as the participants’ skills in SSM and understanding of the enterprise increase.

SSM is a way of securing commitment and taking into account a variety of interests. SSM is gaining popularity, but it has had its share of criticism as well. Some feel that the open-ended nature of SSM makes it difficult to manage and difficult to evaluate whether a SSM project is successful or not; open discussions of problems and needs by managers and employees may empower employees, but are the outcomes of the discussions not influenced by power and politics? And is it the case that what’s good for the organisation is good for the individual? And, does everyone in the organisation have choice or can everyone act on their choices?

SSM is depicted in Figure 5.8.
SSM was originally developed to allow the use of a systems approach to explore social reality, rather than as a means of effecting change, so according to its own aims it has been successful. It is used as part of other approaches, for example total quality management and business process engineering.

The hard systems methodology is used where the degree of clarity and stability is high and the problem is clearly defined. Soft systems methodology is used when there is little or no agreement about the problem.

**Process modelling**

One way of gaining clarification of different views and expectations of a process is to use process modelling. This is a way of increasing understanding of how the current situation works and provides a clear articulation of how the new one is to be different. It does this by capturing visually the dynamics of a situation so that they can be discussed with all those involved. It can be used, for example, in SSM, OD, project management or as a stand-alone diagnostic process.

Three examples of process modelling approaches are:

1. **Process flow** which represents diagrammatically all the stages involved in the completion of a particular process.
2. **Influence diagram** which depicts the ways in which the main components of a system influence each other.

3. **Theory of constraints** (TOC) which applies process modelling techniques to identify bottlenecks. Rather than improving the efficiency of each step in isolation, TOC argues that the throughput of any multiphase process is determined and limited by the speed of the slowest step. Therefore, the process as a whole is analysed, identifying and addressing the bottlenecks, or constraints, that prevent the process from increasing its output.

* These can both be used as part of the SSM process.

**Action research**

The underlying philosophy for OD is action research. Burnes (1996) informs us that this term was coined by Lewin to describe a collective approach to solving social and organisational problems. Action research is based on the proposition that an effective approach to solving problems (managing change) must involve a rational, systematic analysis of the issues in question. According to French and Bell (p.98-9), ‘Action research is research on action with the goal of making that action more effective. Action refers to programs and interventions designed to solve a problem or improve a condition ... action research is the process of systematically collecting research data about an ongoing system relative to some objective, goal, or need of that system; feeding this data back into the system; taking action by altering selected variables within the system based both on the data and the hypotheses; and evaluating the results of actions by collecting more data’.

Coghlan and McAuliffe (2003) argue that what is distinctive about action research and OD is that both follow a cyclical process of consciously and deliberately a) planning, b) taking action and c) evaluating the action, leading to further planning and so on. The second dimension is that both approaches are participative, in that the members of the system participate actively in the cyclical process. The action research approach is powerful. It engages people as participants in seeking ideas, planning, taking actions, reviewing outcomes and learning what works and doesn’t work, and why.

Action research has developed to become a family of approaches, each with its own particular emphasis and yet all following the core tenets of reflecting on experience and participation. Examples of particular approaches within the family of action research are appreciative inquiry, clinical inquiry, action learning, cooperative inquiry and reflective practice. Burnes (1996) stresses that ‘despite its long history, action research is still a highly-regarded approach to managing change’.
Part 6

Enabling change
6.1 Leadership and change

Evans in Cameron et al. (2005:3) says that 21st century leadership of change issues is not simple. He sees modern leadership as a balancing act. He draws our attention to the need for leaders to accept the challenge of navigating between opposites. Leaders have to balance a track record of success with the ability to admit mistakes and meet failure well. They also have to balance short-term and long-term goals, be both visionary and pragmatic, pay attention to global and local issues and encourage individual accountability at the same time as enabling team work.

Vision

Kenny (2005) in his book Achievers: Visionary Irish Leaders Who Achieved Their Dream writes: ‘from recent international studies, we have the chilling fact that two-thirds of the people in leadership positions in the Western world will fail ... The most common reason for their failure is their inability to build or maintain a team’. He explains that everyone in his book ‘built enduring teams’ and that they ‘were never all over the place. They never made promises they could not keep. Their distinguishing characteristic was not an approach or reaction to the world. Visionary leaders see things differently from the rest of us’. He concludes: ‘The thing they had in common was the ability to focus exclusively and unremittingly on their ultimate objective’. He summarises: ‘Focus, absolute but shared focus, is the lesson of this book’.

One of the problems of managing change is that it involves skills outside those normally needed in the day-to-day operational running of the organisation. Given that change programmes tend to have high visibility in organisations, failure to successfully implement the change leaves senior managers vulnerable and exposed. Many senior managers seek to reduce this risk by employing the services of external consultants. Sometimes this strategy is employed because senior management believe that the external consultants bring greater expertise than they themselves possess, but often external consultants are employed because they can be blamed if things go wrong, thus leaving senior management less exposed. Ventris (2004) believes there is ‘a strong case for involving consultants at the early stages of planning and development of the change programme. As mentioned before, the vision is the key component of the programme. External consultants can provide valuable help over the definition of the vision. Being outsiders, they will feel free to challenge senior management rather than accept their ideas without question. It’s important for the vision to be challenged, tested and amended until it’s right, and consultants are often well placed to carry out this task in combination with..."
senior management’. However, external consultants do not always feel able to challenge senior management, as they may be dependent on the same managers for their next contract. Ventris (2004) also argues that there is ‘a key role for consultants to play in talking to employees to find out about the true nature of the company’s culture, discussing how they feel about processes, their managers, their colleagues and other departments. In this context people tend to open up far more to external consultants than they would to their own colleagues or people from another department’. External consultants can often provide a valuable service in this regard, but if they lack the contextual information they may ask the wrong questions. Some would argue that internal consultants are better placed to harness the collective vision of the organisation, because they are likely to be more trusted by their colleagues. Ventris does not advocate using consultants at all stages of the change programme, instead advising that ‘consultants are best kept for the elements of the programme where they can add most value, rather than being allowed to take over the whole exercise’.

**Vision and large-scale reforms**

In the current context of large-scale reforms in the health services in Ireland, there might appear to be an unavoidable gap between the overall vision and what the leaders are capable of achieving through change management programmes locally. According to Ventris, there is no problem with people realising it will take more than one single change management programme to achieve that shining vision. She also denies that one should downgrade the vision so people would feel it is more realistic and attainable. She claims that ‘it pays to have a big, long-term goal that excites and motivates everyone in the organisation, even though they know that it is going to take several change programmes and a whole range of initiatives and investments to get there … It comes down to the importance of honesty and clarity in change management’. She advocates sticking with the big vision, but staying clear about exactly how far each of the separate change programmes are going to take the organisation towards the ultimate goal. She further underlines the importance to ‘be specific about the objective of the programme and take care to explain why it can only take you so far towards the vision. People will want to know about the constrains you are working under and will need to understand, in general terms, what else has to happen before the vision can be delivered. If the vision is a long-term one and everyone in the organisation is aware of that, it is perfectly reasonable to have several self-contained change management programmes over a number of years in order finally to achieve the ultimate goal. You may well need subsidiary visions for each of these programmes in order to keep people focused, but take care to ensure that they relate closely to the overall long-term goal’. This process of open communication is all part of gaining people’s
confidence and trust. Garside claims that ‘one of the paradoxes of change is that during a time of change trust is the most difficult to establish. If the organisation is in the middle of change effort, lack of trust automatically emerges as a serious barrier. Trust in time of change is based on two things: predictability and capability. Staff want to know that a process which is about to begin has a predictable, known route, and that they will be treated fairly’.

Critical to the success of health services reform is the ability to marry the big vision or national reform programme with and strategies that are locally driven to achieve goals that are meaningful at the local level, yet fit within the overall vision or national plan. Unless ownership at the local level can be achieved, there will be little incentive for local action – and lasting reform can only be achieved through local action (otherwise it is relegated to a paper exercise that makes little impact on service delivery). The problems encountered in the introduction of a system-wide human resources IT system (PPARS) provide a good illustration of this point. McDonagh (2006), reflecting on the reasons for the project’s failure, points out that despite the exemplary vision of the project, the fact that it was not a strategic priority shared by the executive leaders of the individual health boards ultimately contributed to its failure.

Leadership styles

‘The best senior manager leaders we studied held their subordinates responsible for starting a change process without specifying a particular approach.’

Beer et al. (1993)

Just as there are many different approaches to change, there are many different styles or approaches to leading change. Many writers (e.g. Dunphy and Stace, 1990) would argue that a contingency approach to leadership, i.e. adopting different styles to suit different situations, is the key to success. However, this assumes that individuals can easily change their leadership style and at a more fundamental level that poor leaders can learn to be good leaders. Thus emerges the age-old question, ‘Are leaders born or made?’, to which there is no conclusive answer. However, we do know that different styles and approaches produce different outcomes.

The Ohio State University leadership studies, and a wide range of studies that used the Ohio framework, are the most widely known examples of the leadership-style approach. They identified a dichotomy between people-centred and task-centred leadership. Two concepts were identified as being important in leadership - ‘initiating structure’ and ‘consideration’. Initiating structure is the extent to which a leader is likely to define and structure his own role and that of subordinates
and provide clear definitions of role responsibility in goal attainment (emphasis is on the task). The second concept, consideration, is the extent to which a leader is likely to have job relationships that are characterised by mutual trust, respect for subordinates ideas, regard for their feelings and open two-way communication (emphasis is on the people). These studies have subsequently been criticised for failing to take situational variables into account (Korman, 1966).

One of the more important works on leadership is Burns’s classic (1978) distinction between transactional and transformational leaders. Transactional leadership emphasises the transaction that takes place between the leader and the subordinate in any situation. This type of leadership occurs when a leader takes the initiative and offers some form of need satisfaction (pay, promotion, recognition) in response to performance. The transactional leader sets clear goals, understands the needs of employees and selects appropriate, motivating rewards. The approach emphasises the importance of the relationship between a leader and his/her followers, focusing on the mutual benefits arising from the ‘transaction’. Transformational leadership involves the use of charisma to transform a vision into shared objectives. The leader goes beyond the norm to bring about changes in the attitudes and behaviour of followers and in the process helps followers identify their full potential (Coghlan and McAuliffe, 2003).

Bass and Avolia (1994) define transformational leadership as something that occurs when leaders:

- Stimulate interest among colleagues and followers to view their work from new perspectives.
- Generate awareness of the mission or vision of the team and organisation.
- Develop colleagues and followers to higher levels of leadership and potential.
- Motivate colleagues and followers to look beyond their own interests towards those that will benefit the group.

Transformational leadership is a process for engaging the commitment of staff to a shared vision and shared values. It is a form of leadership that is particularly important in leading change as it involves a relationship of mutual trust between leader and followers. According to Bass and Avolia (1994), transactional and transformational leadership have been observed to varying degrees in health care organisations. They argue that transformational leadership is an extension of transactional leadership, rather than a separate dimension. In a study of 71 middle managers in the Irish health services, using Bass and Avolia’s Multifactor Leadership Questionnaire, Armstrong (1999) found that over half of the managers scored above the median on both transactional and transformational leadership.
No respondent received a low score on transformational leadership. Carney (1999) argues the case that transformational leadership is the style best suited to nursing, as nurse managers are well placed to work in participative co-operation and to empower staff. McCarthy (1998) writing about leadership in nursing expressed the view that very few transforming leaders had emerged in Irish nursing. She believes that Irish nurse leaders ‘in the main have been the products of autocratic systems and mentored into using primarily transactional roles’ (p. 240). More recently there has been a considerable effort to develop nursing leadership in Ireland through leadership development programmes, mentoring and learning sets.

Mintzberg (1998) takes the image of the conductor of an orchestra as an image for leadership. He illustrates how, far from the notion we tend to have of the conductor as an autocratic dictator, the conductor is a leader of professionals who work with little direction from a manager. Mintzberg notes that what we see as control of the orchestra (sitting in the same seats, playing the same notes, high degrees of coordination, etc.) is a control which comes from the profession, rather than direction from the manager. Hence for Mintzberg, leadership of professionals is covert, rather than overt. The conductor is a leader among equals yet does take the lead and set the pace. Mintzberg makes the connection with hospital surgeons and university professors who describe their structures as upside down with themselves at the top and managers below to serve them.

In an important edited volume of the leader of the future (Hesselbein, Goldsmith and Beckhard, 1996), some of the major writers on leadership – Stephen Covey, Peter Drucker, Charles Handy, James Kouzes and Barry Posner, Edgar Schein and others – explore what it means to lead the organisation of tomorrow, what skills, actions and strategies will be required, and how leaders will need to develop. Repeated across these many writings are arguments for leaders to envision, empower, coach, serve, lead diversity and shape culture, for leaders to be learners themselves and to manage their own self-learning. In discussions on leadership there is a danger in focusing on the leader alone as it tends to propagate the notion of the leader as hero. Coghlan and McAuliffe (2003) assert that the reality is more complex. ‘Leaders are leaders of systems, the dynamics of which enable or inhibit leaders to exercise their function’.

More recently the literature on leadership has shifted towards an understanding of leadership as a supporting role or function in the organisation. This is particularly embedded in the concepts of servant leadership and stewardship.

**Servant leadership**

Servant leadership is a practical philosophy which supports people who choose to serve first, and then lead as a way of expanding service to individuals and
institutions. Servant leaders may or may not hold formal leadership positions. Servant leadership encourages collaboration, trust, foresight, listening, and the ethical use of power and empowerment. Larry Spears, the CEO of the Greenleaf Center for servant leadership gives the following definition of servant leadership. ‘As we near the end of the twentieth century, we are beginning to see that traditional autocratic and hierarchical modes of leadership are slowly yielding to a newer model – one that attempts to simultaneously enhance the personal growth of workers and improve the quality and caring of our many institutions through a combination of teamwork and community, personal involvement in decision making, and ethical and caring behavior. This emerging approach to leadership and service is called servant-leadership.’

**Stewardship**

The concept of accountability and stewardship is far from being merely a politically correct reaction to the current corporate scandals in some countries such as the U.S. It basically says that we need to be good stewards of the material, intellectual, emotional and human resources that are entrusted to us, and that we are always accountable to somebody, either a higher authority (civil, military and/or spiritual) or people who work for us or are served by us. Like loyalty, accountability is also a two-way street. For example, even when one owns a business, he or she is still accountable to the customers, suppliers and/or employees without whose patronage or help the business could not exist. We are also accountable to the society from which we derive much support. In short, everyone in a society is always mutually accountable to one another. An employee is accountable to his/her employer to do a good job; the employer is accountable to the employees by providing reasonable pay, job security, proper treatment, working conditions and advancement opportunities. Stewardship also incorporates the concept of the transient nature of leadership and encourages leaders to take account of the long-term vision rather than focusing on achieving short-term results within their own reign as leader.

**6.2 Internal change agents**

According to Nickols (2000), change management is an ‘area of professional practice’ as much as it is ‘the task of managing change’ and ‘a body of knowledge’. While the use of external consultants, experts or facilitators are common features of change in health system organisations, there is a growing utilisation of internal consultation and change facilitation resources (Hartley, Benington and Binns, 1997; Coghlan, McAuliffe and Pathe, 2002-2003).
There are many advantages of using internal change agents (Steele, 1982; Schwartz, 1984; Hunsaker, 1985; Bor and Miller, 1991; Huffington and Bruning, 1994; Berenbaum, 1997; Coghlan and Brannick, 2001). They know the system and speak the language. They understand the culture and can identify with the needs and aspirations of the people in the system. They are familiar figures in the organisation who are likely to be around for some time and so can build continuity and follow up their work. However, there are also some disadvantages. Internal change agents may lack an objective perspective and be hindered by their past affiliations and how they are perceived by their colleagues. Coghlan and McAuliffe (2003) suggest that they may not have an adequate power base and may not have independence of movement to be effective, i.e. they become pigeon-holed in their traditional roles by comments such as, ‘what does an occupational therapist know about the problems we have in theatre?’ Also their scope of practice or access may be limited by their professional background, e.g. ‘nurses may find themselves confined to working with nurses’. It may be difficult for them to redefine ongoing relationships with fellow organisational members. Coghlan and McAuliffe (2003) suggest that internal change agents or OD consultants may not be seen as ‘prophets’ in their own organisation and may be undervalued, taken for granted, and at times scapegoated. They are dependent on this one organisation of which they are members.

Yet, despite these many caveats, internal change agents are a critical component of any successful change programme. As Ventris points out, not all aspects of the change programme should be left to external consultants. Internal consultants have many advantages over external consultants, not least that they can achieve results more quickly, because of their pre-existing knowledge of the organisation’s culture and people. They know the pitfalls and can prepare for potential resistance. External consultants may be able to take an objective view of an organisation and produce a good diagnostic report, but very few have the knowledge or power to implement their recommendations. This is particularly true in health care organisations, where the complexity of the politics and the myriad of clinical subcultures requires a flexible rather than a prescriptive approach. The numerous consultancy reports that have been commissioned by the health services, and remain unimplemented gathering dust on the shelves of senior executives is testament to this.

Shaping the role

It could be argued that the potential value of the internal change agent in building understanding of and capacity for change is greatly under-exploited in health care. Steele (1982) argues strongly that internal facilitators or change agents need to be proactive about shaping their role, rather than allowing others shape it for them or by waiting for things to happen to them. A role is a set of expectations for a person...
to do a job effectively. Role expectations are never completely explicit, so trying to get complete and full articulation is fruitless. However, when demands don’t feel right or unrealistic expectations are being made then some role clarification and renegotiation are required. Coghlan and McAuliffe (2003) argue that effective role definition depends on the organisation’s needs, the resources of the change agent and the matching of the two. So internal change agents or facilitators need to negotiate whether an expert, resource or process role is required in any project.

Steele also places five dilemmas before the internal OD facilitator or change agent, which in his view are natural positions in any system.

- Helping or controlling – there can be a dilemma between helping a unit or team do what they want to do and trying to get them to do what the boss thinks they should be doing.

- Selling or helping – this dilemma poses questions about the immediate task of working for a group and having an eye on being successful so that there will be future work.

- Doing or learning – there is a tension between seen to be working productively and doing things that don’t look like work, yet are helping the OD facilitator learn, such as reading, sharing experiences, writing up notes ...

- Share the magic or hiding it – this dilemma focuses on how OD facilitators pass on their skills to clients, which in OD is one of the key criteria for success.

- Being safe or taking risks – this tension between security and risk is based on the a) power differential between the internal OD facilitator and the manager, b) the uncertainty of the outcome, c) personal embarrassment and d) violating peer norms.

In Steele’s view there are two approaches to resolving these dilemmas. One is ‘role synchronisation’ by which he means a choice negotiated between the internal OD facilitator and manager, which is what also takes place for external consultants. He notes that some internal OD facilitator activities can irritate the management. These can be: the non-synchronisation of time patterns, such as different time systems, long-term vs. short-term perspectives, and the OD facilitator’s need to hold meetings. Internal OD facilitators may assume inappropriate authority. They may take an arrogant stance or be over-deferent. They may be too abstract or they may not get involved enough and stay in their office too much. These issues are equally relevant for other types of internal change agents. Coghlan and McAuliffe point out that management has an equal propensity to irritate the internal OD facilitators, especially through inappropriate expectations, creating poor conditions for the project such as limiting access or providing inaccurate or too
Guiding change in the Irish health system

little information. If they don’t meet the OD facilitators’ expectations around using resources, keeping promises and not putting things off until a crisis develops, they can irritate them. Management can also exploit the facilitators or change agents by using them in their own power games or by blackmailing them, but management is also capable of manipulating external consultants in similar ways.

**Dealing with organisational politics**

While an organisation may have a clearly articulated espoused theory of its values, strategies and plans for moving into the future, the project of organisational change is inherently political as it constitutes a movement from existing conditions. Coghlan and McAuliffe believe that organisation development, as a change approach, has the propensity to be counter-cultural in many organisations because it examines everything, stresses listening, emphasises questioning, fosters courage, incites action, abets reflection and endorses democratic participation. Any or all of these characteristics may be threatening to existing organisational norms. OD interventions, because of their participative nature, are likely to make differences in values among the various groups or professions much more salient than they would otherwise be. As a result they are likely to increase the likelihood of conflicts and political behaviours, and cause some people to ‘win’ and others to ‘lose’ (Ramirez and Bartunek, 1989).

Internal OD facilitators are engaging in organisational politics, without the benefit of having managerial authority. Change heightens the prevalence and intensity of political action. Many writers argue that change agents should not become involved in organisational politics (Ward 1994, French and Bell, 1995). Only very few have argued that the change agent should have the skills and expertise to handle political issues (Kanter, 1983, Buchanan and Boddy, 1992, Hardy, 1996).

Cooklin (1999) refers to the insider change agent as the ‘irreverent inmate’ who is a supporter of the people in the organisation, a saboteur of the organisation’s rituals and a questioner of some of its beliefs. Accordingly, internal OD facilitators need to be politically astute, becoming what Buchanan and Badham (1999) call a ‘political entrepreneur’. In their view, this role implies a behaviour repertoire of political strategies and tactics and a reflective self-critical perspective on how those political behaviours may be deployed. Buchanan and Boddy (1992) describe the management of the political role in terms of two activities, performing and backstaging. Performing involves the public performance role of being active in the change process, building participation for change and pursuing the change agenda rationally and logically, while backstage activity involves the recruitment and maintenance of support and the reduction of resistance. Backstaging comprises skills at intervening in the political and cultural systems through justifying, influencing and negotiating, defeating opposition and so on. Internal OD facilitators need to be prepared to work the organisation’s political system
by maintaining their credibility as an effective driver of change and as an astute political player. The key to this is assessing the power and interests of relevant stakeholders in relation to aspects of any project (Frohman, 1997). Several models of change cite ‘commitment from top management’ as a key component, implying that if this is present, the whole organisation will row in behind the change. The politically astute change agent realises this is not the case and works to build commitment. Harrison (1995) suggests working with the forces in the organisation which are supportive of change rather than working against those who are defensive and resistant.


1. **Identify the stakeholders.** This means identifying those who have a stake or interest in the project and its outcomes, and approaching them so as to identify their intentions.

2. **Work on the comfort zones.** This means working on those behaviours, values and ideas that a person can accept, tolerate or manage. As long as these are not threatened, people will be able to focus on wider concerns.

3. **Network.** This means going beyond formal hierarchies or structures where necessary to coalitions of interests that may exert greater influence on key stakeholders than the hierarchical structure.

4. **Make deals.** Making deals is common in organisations as individuals and groups agree to support one another on a particular issue in return for support on others. This is a common way of reaching agreement on policies.

5. **Withhold and withdraw.** It may be useful on occasion to withhold information in order not to fuel opposition, though withholding information constantly would not be a good thing. It is also useful on occasion to withdraw from conflictual situations and let others sort out the issue.

6. If all else fails, Kakabadse recommends that OD facilitators need to have some fall-back strategies.

Internal OD facilitators may pose a number of questions to themselves as they plan where to make their interventions. These questions help create awareness of the systemic nature of the organisation and how interventions may be grounded in the dynamics of the system (Harrison, 1995).

- **Accessibility** – Who is accessible?
- **Leverage** – How much leverage do I have? Will I be able to influence this person?
- **Vulnerability** – Is this person open to change?
• Appropriateness – Is it appropriate to work with/through this person, given the structure of the system?

• Linkage – What is the target person’s linkage to the rest of the system?

**Guidelines for survival and success**

Hunsaker (1985) provides 10 principles of being a successful insider change agent.

• Know yourself. • Understand the organisation. • Keep lines of communication open. • Determine how others feel. • Analyse situations from as many points of view as you can. • Have a thorough understanding of all the dimensions of a proposed change. • Be persistent and continually try to make inroads whenever opportunities present themselves. • Develop a sense of timing. • Share credit with others. • Avoid win-lose strategies.

Shepard (1997) provides a few rules of thumb for change agents:

• Stay alive - Care for yourself. Keep a life outside of the project to maintain the ability to turn yourself on and off. Stay in touch with the purpose of the project and go with the flow.

• Start where the system is – Have empathy with the system and the people in it, particularly as it won’t like being ‘diagnosed’.

• Never work uphill – Keep working at collaboration and work in the most promising arena.

• Innovation requires a good idea, initiative and a few friends – Find the people who are ready to work on the project and get them working together.

• Load experiments with success – Work at building success steps along the way.

• Light many fires – Remember the notion of systems. Any part of a system is the way it is because of how the rest of the system is. As you work towards change in one part, other parts will push the system back to the way it was. Understand the inter-dependencies among subsystems and keep movement going in as many of them as you can.

• Keep an optimistic bias – Stay focused on the vision and desired outcomes.

• Capture the moment – Stay in tune with yourself and the situation.

Friedman (2001) suggests four attributes: be proactive and reflective, be critical and committed, be independent and work well with others, and have aspirations and be realistic about limits. In policy terms, Harrison (1995) suggests working in pairs or teams so that an internal facilitator doesn’t have to work alone in high-risk or high-stress situations. He also argues for building personal and professional support systems among internal OD facilitators.
Finally, it is important for the internal change agent to have external reference points and sources of support. Having a personal mentor or sounding board outside of the organisation can be useful in helping the change agent reflect and learn from their experiences. Belonging to a network of change agents can often provide a useful way of gaining support and new ideas can be generated by sharing experiences.

### 6.3 Culture and change

Organisational change failures are often attributed to ‘culture’. Ferlie et al. (1996) assert that longer-term change in an organisational system will not be effected or sustained unless the underlying values and belief systems of the members shift, i.e. unless there is a change in culture. When people talk about what organisational culture is, they typically see it as ‘the way we do things around here’. Coghlan and McAuliffe (2003) assert that the popular literature about organisational culture speaks of climate, becoming a learning organisation or building a team-based culture. Hence, it often focuses on human relations issues, such as communication and teamwork. These are essential elements of culture but are not the total picture.

Schein (1999) describes three levels of culture which go from the visible to the invisible or tacit. The first level is the artifact level. These are the visible things – what we see, hear and feel as we hang around an organisation – the visible layout of the office, whether people work with their door open or closed, how people are dressed, how people treat one another, how meetings are conducted, how disagreements or conflicts are handled, and so on. The difficulty about these visible artifacts is that they are hard to decipher. We don't know why people behave this way or why things are this way.

When we ask these questions we get the official answers, the answers that present the values that the organisation wants to pertain. This is the second level of culture – organisational values. Open doors are a sign of open communication and teamwork, first name greetings are a sign of informality. Yet we know that this is not always true, that organisations, not unlike individuals, do not always live up to what they espouse, not necessarily due to any deliberate attempt to deceive but for complex unknown hidden reasons. A more common answer to our question is more likely to be, ‘I don’t know; they did things this way long before I joined and I got the message early on that this is how we do things here’.

So we come to the third level of culture, that of shared tacit assumptions. These are the assumptions which have grown up in the organisation and which have made it successful. They are typically tacit or hidden because they have been passed from
generation to generation within an organisation and organisation members don’t see them any more because they are taken for granted.

Coghlan and McAuliffe (2003) argue that when we look at change initiatives and why they haven’t worked or achieved their intended outcomes, the answer is likely to be that the initiatives violate some taken-for-granted assumptions that are embedded in the organisational psyche because they were successful in the past. That is the key. Because something is successful at some point in time, it gets passed on as ‘the way we do things around here’. Schein sees culture as ‘the sum total of all the taken-for-granted assumptions that a group has learned through its history’ (1999:29). Therefore, an organisation’s culture is deep – it controls us more than we control it. It is broad and it is stable as it sets predictability and normality and hence changing it evokes anxiety and resistance.

While the notion of culture is abstract, it is also very concrete. There is no right or wrong, better or worse culture. These are judgements that can only be made in terms of what an organisation is trying to do. Appropriate or inappropriate culture only makes sense in the context of what a particular organisation is trying to do and what assumptions an organisation needs to hold to be successful in its environment.

However an understanding of the culture one is attempting to change is critical to the success of that change. It was this recognition of the importance of understanding culture that prompted the OD Unit of the former North Eastern Health Board (now HSE Dublin North East) to undertake a survey of the organisation’s culture (An exploration of culture in one Irish health service organisation, 2005) in order to inform its work in developing the organisation. The survey was constructed on the basis of six core cultural components, namely people orientation, information and communications, leadership and direction, accountability and performance, integration and teamworking, and continuous improvement and development. The final section of the questionnaire explored views on the national reform process in the Irish health system. The findings revealed the existence of several subcultures within the overall culture and thus pointed to the need for different strategies to manage change in different sections of the organisation. For a more in-depth discussion of the literature on the relationship between organisational change and subcultures, see Chapter 4 of An exploration of culture in one Irish health service organisation, 2005.

The cultural theory of organisations as described by Weeks and Gallunic (2003) holds that an organisation is ‘a culture bearing entity, wherein the concept of culture includes shared knowledge, but also the other modes and forms of shared beliefs, meanings, values, behaviours, language and symbols in the firm’ (2003:1311). Culture-based theories place greater emphasis on human interaction
and behaviour within the organisation and much less emphasis on the behaviour of the external market in determining the future of the organisation. They also share a view of organisations (or culture and knowledge) as self-generating or self-organising, emphasising therefore the importance of social control in guiding the growth and direction of the organisation (Kiernan, 1993; Tushman and O’Reilly, 1997, 1999; Weeks and Gallunic, 2003).

A particular problem with strategic planning as a vehicle for changing an organisation is its focus on long-term prediction and its assumption that it is possible for an individual or group to perceive an objective reality, i.e. to step outside the organisation and have an objective view of that organisation. This is based on a cognitivist perspective, i.e. an individual perceives an objective reality and acts on that. Strategic choice theory adopts this cognitivist perspective and assumes that senior management can step outside of their organisations, take an overview and develop a model or a plan that will help them control the organisation and its activities. The theory holds the assumption that successful change in organisations is based on senior managers’ ability to predict what lies ahead and plan accordingly. In contrast to this, the constructivist perspective holds that an individual acts on the basis of perceptions built up through past experience and in so doing selects or enacts an environment. An individual cannot perceive an objective reality but only what his or her experience makes it possible to perceive.

Weick, taking a constructivist view of human psychology, views organisations as ‘sense-making systems’. He believes that managers create the reality they respond to. He argues that organisations incessantly create and recreate conceptions of themselves and all around them that seem sensible enough and stable enough to be manageable. Weick is therefore implying that the organisation’s direction is path-dependent, in that the future is influenced by what is already known and shared within the organisation. This sense-making process is itself a form of control.

Schein (1992) considers the organisation as a group, and analyses organisational culture as a pattern of basic assumptions shared by the group, acquired by solving problems of adaptation and integration, working ‘well enough to be considered valid, and, therefore, to be taught to new members as the correct way to perceive, think and feel in relation to those problems’ (1992:374). Schein links organisational culture to learning organisations by arguing that in a world of turbulent change, organisations have to learn faster, something which requires a culture that functions as ‘a perpetual learning system’ (1992:372). Argyris (1999) highlights the internal inconsistency in the notion of managing culture when he says; ‘cultures are usually seen as growing up and evolving, rather than as objects of direct control’ (1999:5). He criticises Schein for arguing simultaneously that the
culture of an organisation can be shaped by its leader and that culture evolves in response to selective pressures exerted by external and internal environments. The notion of cultures as objects of direct control is one that also concerns Pascale. He highlights the paradox of culture and argues, ‘The crux of the dilemma is this: We are intellectually opposed to the manipulation of individuals for organisational purposes. At the same time, a certain degree of social conformity enables organisations to work better’ (1985:28-29). He sees the challenge for managers as being to reconcile the need for some degree of socialisation (which he maintains is necessary for organisational effectiveness) with the ‘American insistence upon the latitude for retaining independent action’. (1985:29).

The challenge is to achieve this balance. Many of the Japanese companies that were successful in the 1980s and early 1990s promoted social conformity among their employees through common dress codes, corporate values and behaviours. In the current climate of individualism, such practices are unlikely to attract and retain employees. Perhaps what is needed is a shared set of values that will ultimately result in common codes of behaviour and practice in an organisation. Rather than attempting to instil shared values, it may be necessary to shape recruitment processes so that gradually a predominant set of values emerges in the organisation. However, much research is required before we develop a full understanding of the impact of emerging culture on an organisation’s adaptability and performance.
PART 7 MANAGING CHANGE

7.1 Levels: individual, team, organisation

Organisational change is a multi-level activity as fundamental systemic change requires behavioural change on several levels. This is not easy as interventions on one level may contradict interventions on other levels – an individual incentive scheme may work against teambuilding (for example a performance management system that rewards individual achievement). It may also be that what is intended as multi-level change may not in fact be so – teambuilding for the top management team may not have an organisation-wide impact. Change agents should be aware of the issues occurring at each level and how one level affects another, and be able to work with individuals, teams and inter-team groups to evaluate the effect of one level on another. In this process of evaluating the impact of one level on another, OD practitioners must take notice of the systemic nature of the relationship between each of the levels, that is to say, to construct how the relationship between one level and another works in both directions. When relationships are viewed as systems, then there is no simple cause-and-effect linear chain. There is no direct line of blame. Each element in the system both causes and is caused by the other elements.

From management’s perspective, the core issue is one of participation. The most basic participation is to get a person committed to the goals, values and culture of the organisation. The second level of participation is to establish good, working face-to-face relationships in functional teams. Finally, the most complex of all is the unified effort of all participants in an organisation towards the end of making the organisation functional in its external environment. In a hospital environment it is the unified effort of all that makes possible the diagnosis, treatment and care of patients that are referred from primary care.

Individual level

‘Although organisational change is often about change in structures, hierarchy, reward systems, and technology, it is mediated through individual change’ (Schein, 1980). Devos et al. highlight that ‘many change efforts can fail because they underestimate the importance of this individual, cognitive-affective nature of organisational change’.

Nickols (2000) explains that ‘A person’s placement in the organisation typically defines the scope and scale of the kinds of changes with which he or she will become involved, and the nature of the changes with which he or she will be concerned.’ Thus, the systems people tend to be concerned with technology and
technological developments; the marketing people, with patient needs; the legal people, with legislative and other regulatory actions; etc. He further claims that ‘the higher up a person is in the hierarchy, the longer the time perspective and the wider-ranging the issues with which he or she must be concerned’.

According to Cameron and Green (2005), there are four key schools of thought when considering individual change:

- **The behaviourist** approach is about changing the behaviours of others through reward and punishment. This leads to behavioural analysis and use of reward strategies. Interventions to facilitate the change process are: performance management, reward policies, values translated into behaviours, management competencies, skills training, management style, performance coaching and 360 degree feedback.

- **The cognitive** approach is about achieving results through positive reframing. Associated techniques are goal setting and coaching to achieve results. Suggested interventions here are management by objectives, business planning and performance frameworks, results-based coaching, beliefs, attitudes and cultural interventions, and visioning.

- **The psychodynamic** approach is about understanding and relating to the inner world of change. This is especially significant when people are going through highly affecting change. Interventions are understanding change dynamics, counselling people through change, surfacing hidden issues, addressing emotions, and treating employees and managers as adults.

- **The humanistic psychology** approach is about believing in development and growth, and maximising potential. The emphasis is on healthy development, healthy authentic relationships and healthy organisations. Main interventions considered here are living the values, developing the learning organisation, addressing the hierarchy of needs, addressing emotions, and fostering communication and consultation.

Lewis’s (1991) model of change considers the key requirements for an individual to change. He focuses on changes internal to an individual, for example changes to an individual’s system of beliefs. Lewis says that individuals have a better chance of dealing with external changes than organisations, providing these changes do not have a direct impact on the individual concerned. Lewis’s matrix in Figure 7.1 explains his theory.
<table>
<thead>
<tr>
<th>Subjective factors</th>
<th>Task-related aspects</th>
<th>Personal aspects</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Individual skills and knowledge</td>
<td>Individual’s feelings</td>
</tr>
<tr>
<td>Objective factors</td>
<td>Working conditions, task demands and resources</td>
<td>Perceptions of other people and interrelations between people</td>
</tr>
</tbody>
</table>


The environment structure is external to the individual and in the model surrounds the matrix. Mental and emotional structures and self-concepts are internal to the individual and fall within the matrix. Two of the four quadrants refer to what Lewis calls objective factors. One of these deals with working conditions, demands and resources, and the second deals with other people’s perceptions and interrelations. The remaining two quadrants deal with subjective factors, one the individual’s skills and knowledge, and the other the individual’s feelings. In order to successfully implement change, Lewis suggests that it is necessary to identify which of these quadrants is required to change, because different skills are needed to change each one. Lewis’s (1991) model is unusual in that it focuses on the micro issues pertaining to change, such as the individual’s feelings.

Coghlan and McAuliffe (2003) believe that it is the function of management to motivate each individual in the organisation in the hope of enhancing growth and effectiveness. Therefore, management’s ideal goal is to create a matching process in which people are able and encouraged to become involved, and find that the work situation develops them as human beings while the organisation benefits from such an involvement (Schein, 1978, 1993). Not all individuals relate to management’s goals in this regard, and some prefer to define their relationship with the organisation in political and adversarial terms with the core issues at stake being power and control (Fox, 1985; Bolman and Deal, 1999).

**Teams**

The team level is a more complex level than the individual because of the increased number of participants and interactions. Teams are parts of a wider system in organisations and some of the dysfunctional issues that arise within the team may originate beyond the team in its technological and political interface with other teams. From the managerial perspective, any individual’s task within the face-to-face team is to contribute to the collective ventures of the team. Management requires the team to be efficient and cooperative in its output toward the overall organisational task. Effective team functioning requires the team to be successful in accomplishing its tasks and skilled in learning from its experience in building and maintaining working relationships.
Coghlan and McAuliffe (2003) argue that it is critical for face-to-face teams to develop the appropriate skills of self-reflection and correcting their own dysfunctions. Such skills typically constitute the definition of successful teams. Team dysfunction occurs when assumptions, attitudes and behaviour of team members towards one another and the team’s effort frustrate the team’s performance (Wheelan, 1999). Generally, the discovery of negative information is not valued in many organisations as people then tend to fail to confront one another or else confront one another out of learned patterns of inference, attribution and the placing of blame (Argyris, 1990). Behaviours such as blaming, withholding information, inappropriate team leader style, misplaced competition, sexism and racism, and lack of trust can negatively influence the team members’ capacity to work well together and also inhibit team development. Furthermore, within any given team the interaction skills of task achievement and maintenance function may not be equally developed.

When considering how individuals affect team dynamics, it can be beneficial to use the Myers Briggs Type Indicator (MBTI). Further, Belbin’s research into team types is used to indicate what types of individuals best make up an effective team.

According to Cameron and Green (2005), the MBTI suggests that if you are a particular type, you have particular preferences and are different from other people of different types. This means that when it comes to change, people with different preferences react differently to change, both when they initiate it and when they are on the receiving end of it. This is also true when you are a member of a team.

When undergoing team change, individual team members will typically react in one of four ways:

1. **If it ain’t broke, don’t fix it.** Some will want to ascertain the difference between what should be preserved and what could be changed.

2. **Let’s think ahead.** Some will think long and hard about the changes that will emerge internally from their visions of the future. They will be intent on thinking about the changes differently.

3. **Let’s just do it.** Some will be keen to move things on by getting things to run more effectively and efficiently. They will be most interested in doing things now.

4. **Let’s change it.** Some will be particularly inventive and want to try something different or novel. They will be all for changing things.

The use of the MBTI, or any other personality-profiling instrument, can have specific benefits when teams are experiencing or managing change. It can identify
where individuals and the team itself might have preferences to be capitalised on, and where individuals might have preferences that need to be supported. 

Researching the health care industry, McCaulley (1975) made the point that similarity and difference within teams can have both advantages and disadvantages:

• The more similar the team members are, the sooner they will reach common understanding.

• The more disparate the team members, the longer it takes for understanding to occur.

• The more similar the team members, the quicker the decision will be made, but the greater the possibility of error through exclusion of some possibilities.

• The more disparate the team members, the longer the decision-making process will be, but the more views and opinions will be taken into account.

McCaulley also recognised that teams valuing different types can ultimately experience less conflict. Cameron and Green (2004) continue by saying, ‘a particular case worth mentioning is the management team. Management teams, both in the United States and the United Kingdom are skewed from the natural distribution of Myers Briggs Types within the whole population. Typically they are composed of fewer people of the feeling types and fewer people of the perceiving types. This means that management teams, when making decisions around change, are more likely to put emphasis on the business case for change, and less likely to think or worry about the effect on people. You can see the result of this in most change programmes in most organisations. They are also more likely to want to close things down, having made a decision, rather than keep their options open – thus excluding the possibility of enhancing and improving on the changes or responding to feedback’.

Belbin (1981) has been researching what people characteristics need to be present for a team to function effectively for a number of years. The purpose of his research was to see whether high- and low-performing teams had certain characteristics. He looked at team members and found that in the higher-performing teams, members played a number of roles. He identified the following roles:

• **The chairman**: coordinates the working of the team towards its objectives, using his or her communication and people skills. Quite people focused.

• **The shaper**: focuses on task achievement. Attempts to bring shape and structures to the team’s direction, using enthusiastic and proactive attitude.
• **The plant:** generates ideas from the team using imagination and intelligence, working at a high level rather than with the detail.

• **The monitor-evaluator:** has the ability to see how things are going. Takes in information, collates, interprets and evaluates data and progress.

• **The company worker:** is quite the pragmatist. Able to translate ideas into tangible actions. Aims for stability and agreed courses of action.

• **The resource investigator:** has the ability to go out and ensure the necessary resources are obtained through his or her networking and interpersonal skills and positive attitude.

• **The team worker:** focuses on the team’s well-being by being able to read the signals of the team dynamic and arbitrate, mediate and facilitate the team through difficult emotional terrain.

• **The completer-finisher:** keeps working to meet deadlines. Very detail conscious and disciplined in his or her approach to task completion.

Any teams without members playing one of these roles would be more likely to perform at a lower level of effectiveness. Belbin concluded that if teams were formed with individual’s preferences and working styles in mind, they would have a better chance of team cohesion and work-related goal achievement. Cameron and Green (2005) comment in this context: ‘Teams need to contain a good spread of Belbin team types. Different teams might need different combinations of roles. Marketing and design teams probably need more plants, while project implementation teams need company workers and completer finishers. Likewise, the lack of a particular team type can be an issue. A management team without a chairman or shaper would have problems. An implementation team without a completer-finisher might also struggle.’

Also, teams develop over time. Tuckman’s model of team change (forming, storming, norming and performing) is useful for understanding this process. Cameron et al. summarise that teams can become more effective by addressing the following five elements:

1. Team mission, planning and goal setting.

2. Team roles.

3. Team operating processes.

4. Team interpersonal relationships.

5. Inter-team relationships.
OD has long focused on the pivotal role of groups in organisational change. The process of organisational change typically involves the change agenda being assessed and responded to by the permanent working teams in the organisation’s structure and by the involvement of temporary committees, task forces or action learning sets in solving problems, creating policy or generating commitment.

**Organisation**

Coghlan and McAuliffe (2003) assert that ‘the organisation’s tasks are to have a unified corporate identity and to exist in a competitive environment. Consequently, an organisation needs to be capable of reflecting on its own strengths and weaknesses, as well as engaging in proactive relationships to determine and deal with the opportunities and threats from the external environment. The assessment of strengths, weaknesses, opportunities and threats result in a selection process which establishes programmes and services. These procedures aim at accomplishing the goals of the organisation and adapting to external environmental demands. An awareness of the cultural assumptions which underlie any organisation’s policies, strategies, structures and behaviours contributes to the successful completion of the tasks at this level’.

Senior managers have the job of working out what an appropriate approach to strategy would be, who should be involved in the processes of planning, developing options and implementation, how the process could work most effectively, and what additional expert external help could be utilised. OD practitioners can help the members of an organisation clarify its core mission, map the internal and external constituencies which make demands on the organisation and its strategic choices, assess the strengths, weaknesses, opportunities and threats both externally and internally. OD practitioners can also help members of an organisation question the assumptions underlying the management and implementation of planning processes and take steps to deal with those issues which, if not attended to, would ultimately lead to failure (Argyris, 1985).

A critical process is how the imperative for change is communicated across the organisation (Quirke, 1996). Each of these movements – from individual to team to interdepartmental group – is an iterative process (Rashford and Coghlan, 1994). In other words, when the team adopts an individual’s position, that adoption reinforces the individual. When other teams adopt a particular team’s position, that reinforces that team, and, of course, when customers adopt a new service, that reinforces the organisation. Thus organisational change cannot really be successfully tackled without paying attention to each level.
7.2 Response to change

Heathfield (2006) stresses the link between communication and response to change in that, ‘People who are afforded clarity, honesty, dignity, understanding, and compassion have a greater openness to change,’ and, ‘Expressing the reasons for change honestly and directly will help people be open to change’. Kanter et al. (1985) argue that change is only successful when the entire organisation participates in the effort. He outlines that people within an organisation can be divided into three broad change categories: change strategists, change implementers, and change recipients. ‘In health care organisations, the strategists could be considered to be the board of senior managers and professional leadership, the implementers are the project coordinators for quality improvement or audit team, and the recipients are most of the staff of the hospital or other health organisation’, according to Garside (1998). Another author that is often cited in this context in particular is Rogers (1983) who suggests there are five categories of adopters of innovations: innovators, early adopters, early majority, late majority and laggards. He claims that the distribution of these groups in a given population corresponds to a bell-shaped curve.

Stocking (1992) outlined a typical example of the above which characterises the farmer population in terms of the five adopter categories and claims that ‘this typography requires only minor amendments to be applicable to health practitioners’.

<table>
<thead>
<tr>
<th>Adoptive Category</th>
<th>Personal Characteristics</th>
</tr>
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<tbody>
<tr>
<td>Innovators</td>
<td>Highest social status, largest and most specialised operations, wealthy, often young, well educated</td>
</tr>
<tr>
<td>Early adopter</td>
<td>High social status, often large and specialised operations</td>
</tr>
<tr>
<td>Early majority</td>
<td>Above average social status, average sized operations</td>
</tr>
<tr>
<td>Late majority</td>
<td>Below average social status, small operations, little specialisation, relatively low income</td>
</tr>
<tr>
<td>Laggards</td>
<td>Little specialisation, lowest social status, smallest operations, lowest income, often oldest</td>
</tr>
</tbody>
</table>

Figure 7.2: Characteristics of adoptive categories among farmers. Adapted from Stocking, B. (1992).

Many other authors have categorised people in a similar way, but with different labels. For instance, Winters (2003) developed a 6-F model in order to describe how people respond to change: ‘the foggies, the fakers, the faultless, the fearful, the fighters and the futurists’.
Receptivity and change
Pettigrew, Ferlie and McKee (1992) conducted a longitudinal research study on eight Regional Health Authorities in the NHS over a four-year period. They were particularly interested in why the rate and pace of change differs across different localities. They believe that some contexts or environments are more receptive to change than others. Kanter (1985) also distinguishes between different contexts and their receptivity to change. She describes organisations as integrative or segmented. Integrative structures or cultures with their team-oriented, cooperative environments are innovation stimulating. Segmented structures, characterised by compartmentalised problem-solving, hierarchies and rules, inhibit innovation. Kanter (1989), in her book *When Giants Learn to Dance*, argues that ‘flexibility and adaptability will come from being person- not position-centred, creation-not efficiency-oriented, results- not rules-oriented, a team and not a hierarchical preoccupation, and from a drive for leverage and experimentation and not a search for ownership and control’ (Kanter, 1989:353).

Pettigrew, Ferlie and McKee (1992) in their study of the NHS revealed eight receptivity factors as being important determinants of the success of the change process (see Figure 7.3).

Figure 7.3: Receptive contexts for change: the eight factors. Pettigrew, A. Ferlie, E. and McKee, L. (1992).
Quality and coherence of policy
The quality of policy generated at local level was found to be important, both from an analytical as well as a process perspective. Using data to substantiate the case for change and framing this data within clear conceptual thinking was equally important. Strong testing of initial thoughts was important in ensuring that there was coherence between the proposed strategic framework and the goals of the organisation.

Availability of key people leading change
Strong leadership from the key change agents coupled with continuity were considered important. The authors draw evidence from the literature of the link between the unplanned movement of key personnel and the draining of energy, purpose, commitment and action from major change processes. They suggest that a corollary of this problem is ‘that the change process or programme then goes into a period of regression leaving the newcomer manager to start again but now possibly in a soured and non-receptive context for change’ (Pettigrew, Ferlie and McKee 1992:278).

Long-term environmental pressure
They argue that contrary to the idea that large-scale environmental pressure can act as a trigger for or driver of change, in the NHS excessive pressure can deflect or drain energy out of the system. In some of the district studies, financial crises created delay, denial, collapse of morale, and scapegoating and defeat of managers. In others, financial crisis was played up and skilfully orchestrated by management in order to accelerate the process of rationalisation and change.

A supportive organisational culture
Cultural change is an aspect of change that requires huge energy. Pettigrew et al. (1992) argue that ‘rewards, broadly defined may be important, and that there is an extremely important role for Human Resource Management policies and practices, somewhat neglected perhaps in the NHS in the past’ (1992:281).

Health services organisations are not characterised by a single culture, but a whole myriad of subcultures. Pettigrew et al. (1992) identified a number of features of the managerial subculture at district level that were associated with a high rate of change:

• Flexible working across boundaries with purpose-designed structures rather than traditional hierarchies.
• Openness to research and evaluation.
• A strong value base which helps to give focus to what otherwise might be a loose network.
• Strong positive self-image and a sense of achievement.
Effective managerial-clinical relationships
The importance of effective managerial-clinical relations in stimulating strategic change has been reported in studies of the U.S. health care system. Manager-clinician relations in the NHS study were found to be easier where negative stereotypes had been broken down. This can happen with the emergence of mixed roles, i.e. clinicians with a managerial role. It is important that managers understand what clinicians value as this will allow them to negotiate or trade more successfully with them.

Pettigrew et al. identify clinical directors as strategic clinicians that are critical people for management to identify, foster and encourage and that ‘under no circumstances should they be driven into opposition by trivia’.

Cooperative inter-organisational networks
The most effective networks with other agencies were those that were both informal and purposeful. The significance of purposeful networks and their role in trust building and negotiating is something that Kanter (1985) considers important in achieving substantive change.

Simplicity and clarity of goals and priorities
It is important to be able to narrow the change agenda down to a key set of priorities and to be patient in pursuing these over a long period of time. If the constantly shifting short-term pressures in the NHS cause an escalation in the number of priorities, there is a danger that they may become meaningless to the organisation.

The fit between the district’s change agenda and its locale
There are a number of factors that proved important to the districts’ plans for change, among them whether there was one large population centre or two or more, and whether there was a teaching hospital presence, the nature of the local NHS workforce, and the strength and nature of the local political culture.
7.3 Failure

‘If you want to learn the secrets of success, it seems perfectly reasonable to study successful people and organisations. But the research of Denrell (2004) suggests that studying successes without also looking at failures tends to create a misleading – if not entirely wrong – picture of what it takes to succeed.’

Jerker Denrell, Assistant Professor of Organisational Behaviour, The Stanford Graduate School of Business, California.

When reading through the literature on change management, organisational change looks seductively easy. But the reality appears to be more challenging. Beer et al. (1996) claim that ‘Change programmes … are often highly developed, visible, expensive processes that often do not result in successful change’. Garside found that ‘despite the best efforts of senior management, the success rates of major change programmes … are estimated between 20% and 50%’. Strebel (1996) claims that ‘the reason is simple – leaders and employees see change differently. To the leaders, change is an opportunity, a survival strategy, a chance to further their careers. To the employees, it is disruptive and intrusive’.

Garside (1993) claims that one of the paradoxes of change is that during a time of change, trust is the most difficult to establish. If the organisation is in the middle of change effort, lack of trust automatically emerges as a serious barrier. Trust in time of change is based on two things: predictability and capability. Staff want to know that a process which is about to begin has a predictable, known route, and that they will be treated fairly. They also want to think that those who are in charge are capable of delivering what they promise. In the widespread reorganisations and reviews of acute health services change in the United Kingdom and abroad, it has been shown repeatedly that carefully thought out macro plans for rearranging, merging, and closing services are extraordinarily difficult to accomplish. Equally, the micro or process change involved in quality improvement in clinical services is also difficult to achieve. The implementation part of the process is one in which many organisations fail, or fail to complete. Increasingly, managers and clinical professionals in health care are coming to terms with the need for carefully designed and implemented programmes for change, programmes which take into account the external world and its pressures – politicians, professional groups, and the public – and the internal world of the organisation – its culture, norms, and staff behaviours.

Another cause for failure has been highlighted in one of the conclusions of the Garside (1993) review of patient-focused care. It was claimed that ‘leaders of
change significantly underestimated the need for investment in support from human resource (personnel) professionals in the technical aspect of changing people’s jobs, recruitment, redundancy, training and communication with staff’ as major areas for improvement. Recommendations following that study were to involve staff in the process of change, train and develop individual people and that one of the keys to cultural change and to unlocking resistance to change is effective communication.

Reflecting on the failure of a major human resources IT project (PPARS) in the Irish health services, McDonagh (2006) echoes the need for capacity building and commitment. ‘Any public service organisation that intends to modernise is ill advised to do so in the absence of a serious commitment from its executive leaders to deliver on the agenda for change. If there is no assessment of current capability and capacity, no strategy for capability and capacity building, and no strategy for empowering leaders to embrace the challenge of change, the prospect of failure is always present’.

Kotter (1990) concludes in his book *A Force for Change: How Leadership Differs from Management* that there are eight reasons why many change processes fail:

- Allowing too much complexity.
- Failing to build a substantial coalition.
- Not understanding the need for a clear vision.
- Failing to clearly communicate the vision.
- Permitting road blocks against the vision.
- Not planning and getting short-term wins.
- Declaring victory too soon.
- Not anchoring changes in corporate culture.

### 7.4 Working with resistance

> ‘Progress is a nice word. But change is its motivator. And change has its enemies.’

*John F. Kennedy*

#### Causes of resistance to change

Based on Lewin’s force-field analysis – as outlined above – resistance to change by organisational stakeholders is a strong restraining force. Cameron and Green (2005) explain that ‘used in connection with Lewin’s force field, we see that survival anxiety is the driving force and learning anxiety is a restraining force’.
The ‘recipients’ – as Kanter et al. (1985) call them – resist change not purely on emotional grounds. According to Garside (1998), they resist ‘for reasonable and predictable reasons’. She cites reasons why stakeholders might resist change:

- **Parochial self-interest**: Parochial self-interest is problematic in situations where stakeholders expect to lose something as a result of the change being implemented; it may include factors such as loss of power, loss of face, additional workload, loss of income, job insecurity.

- **Resentment**: Resentment develops either with particular people who are sponsoring change, with change in itself (often called change fatigue), or due to the increased presence of power and authority as a result of the number and range of instructions that almost inevitably flow from management in implementing change.

- **Different perceptions of change**: Different perceptions of change often depend on a person’s position within an organisation and their access to information.

- **Misunderstanding or lack of trust**: Misunderstanding or lack of trust is often a symptom of poor organisational communication.

- **Low tolerance for change**: Low tolerance for change tends to be based on the fear of being unable to learn new skills or work behaviour.

She further emphasises that ‘these factors focus primarily on resistance to change at an individual level of analysis. It is, however, important to note that there may be resistance at group and organisational levels. Groups may, for example, resist change if their group structure, social norms, or power base is affected. At the organisational level, it has been suggested that a series of interrelated factors may contribute to resistance, including organisational structure, culture and strategy. More broadly, resistance to change has been characterised as cognitive blockages:

- The ‘don’t need to change’ blockage based on the inability or unwillingness to monitor the organisational environment for forces for change;

- The ‘can’t change’ blockage which often centres around the lack of resources or power; and

- The ‘won’t change’ blockage which is primarily linked to political issues in which people or groups think that the costs of change outweigh potential benefits’.

Zaltman and Duncan (1977) have described five ways in which teams function to resist change: team solidarity, rejection of outsiders, conformity to norms, conflict and team insight. Coghlan and McAuliffe (2003) explain that, ‘A change process frequently involves inter-team conflict in organisational settings where the change
is promoted by a management/administration group and those affected by the change feel apart from that group and oppose the change. In such situations, groups can bond together in opposition to other groups and so begin the process of selective perceptions, distortions and stereotyping of the other groups. Communication becomes difficult and it is not uncommon to require a mediator or third party to facilitate communication and resolution of the conflict.

**Working with resistance to change**

Vas et al. (2005) revisit the concept of resistance to change. They say that the literature in change management defines resistance to change as ‘a negative, irrational, counter-productive phenomenon conducted by a minority of organisational actors that managers must overcome’. Their study, on the contrary, highlights that ‘reluctance to change’ is a core component in the implementation of change studied by them. Their paper questions the assumption ‘that resistance to change is an enemy to change and should be overcome’. They argue that change leaders should encourage participants or recipients to express reluctance to change and suggest that, ‘They will be more able to identify real problems that must be solved, and fears that key actors may have in the effective process of change.’

Coghlan and McAuliffe (2003) argue that resistance to change is usually perceived as a disruptive force that needs to be overcome in order to move the organisation forward. ‘It is a label applied by managers and consultants to the perceived behaviour of organisational members who seem unwilling to accept or implement an organisational change. It is typically used by those who are agents of change and tends not to be used by those who are the targets of the label to describe themselves.’ They take the view that resistance is something to be worked with, rather than something to be overcome. ‘Overcoming’ resistance tends to imply a coercive approach and such an approach is likely to lead to increased resistance and opposition (Nevis, 1987; Goldstein, 1989). The OD approach to resistance is to treat it with respect by considering it as a healthy, self-regulating manifestation which must be taken seriously.

The most common OD guidelines for working with resistance are: involve people in the planning of change, provide accurate and complete information, give employees an opportunity to air their objections, provide adequate motivation, develop a trusting climate, take organisational culture into consideration and use problem-solving approaches. Kotter and Schlesinger (1979) outline a number of approaches (education, participation, facilitation, negotiation, manipulation and coercion) for working with resistance and show in what situations they are commonly used and the advantages and disadvantages of each approach. For example, they point out that building support through facilitation is very useful
when people are resisting because of adjustment problems, but can be time-consuming and expensive, and still fail.

Coghlan and McAuliffe’s (2003) conclusions on the nature of resistance and how to work with it are worth noting.

- Resistance is a natural phenomenon; it is an essential element in understanding change.
- Resistance to change has its origins in the personality and the situation. The personality is typically cited as the cause of resistance, while resistance is more commonly caused by the situation.
- Resistance is not passive but is rather a dynamic energy.
- Resistance has both a cognitive and an emotional element.
- There are differing degrees of acceptance to change and resistance to it – from enthusiastic acceptance and cooperation through passive resignation, indifference, apathy and passive resistance to active and open opposition.
- Resistance is viewed generally from the perspective of those promoting change and there is a need to understand the perspective of the defenders.
Resistance should be taken seriously, by being listened to, understood and acted on; it is an occasion for the change agents to look again at the change project and review omissions or errors and modify it in the light of feedback.

7.5 Critical success factors

The importance of involvement and participation is emphasised strongly throughout the change management literature. O’Brien explains that, ‘Public sector reform has focused attention on how different models of change can contribute to organisational metamorphosis. Traditional ‘top down’ approaches are unlikely to achieve the necessary change’. Instead, using a case study of an Irish public sector organisation, the author argues that direct participation and involving frontline staff ‘can play a key role in ensuring acceptance of change and in creating the conditions for employees to make effective contributions to their organisation. Direct participation plays a vital role in employee development. However, it also places demands on organisations to adopt a more facilitative and supportive style of management and to put in place mechanisms that will ensure that participation becomes an integral part of the work process’.

Heathfield (2006) stresses that establishing trust is a first step towards successful change. She summarises, ‘If you fix the trust thing, you’ve removed many of the barriers to positive change. So, fix the trust thing; walk the talk; communicate; tell the truth; involve the people; set goals; help people learn and develop; measure results. We know that these are the foundations, not just for effective change management, but for effective organisations as well’.

She also focuses attention on the importance of a vision and explains: ‘Human behavior is very complex, but I honestly believe that organisation change is often overcomplicated by bad execution and lack of clarity and a plan. Change principles are simple (does not mean easy). In my opinion, 70-90% of the successful change efforts I’ve been involved in have focused very heavily on the basics ... Those that failed usually did so not for poor intent or a bad company strategy, but because of bad CHANGE strategy and implementation. More MBA and other business degree programs should concentrate on Human Performance Improvement and Organisation Development principles. Better identification and selection of leaders would also help staff the top ranks of organisations with those who are better emotionally suited to produce change. Successful change management strategies require not only an awareness of human behavior, but also workplace evolutionary trends. Many consultants only see half the picture and rely on historical evidence of successes. The workplace trends we are seeing do not have historical context, thereby this tactic will eliminate many potential ‘solutions’ that previously may have worked’.
Heathfield also advocates for:

- A theoretical framework to underpin the change.
- Doing risk assessments early on and having a specific mitigation plan for all the major risks.
- Clarity of mission, vision and objectives for the change effort. Creating an urgency around the need for change.
- Creating and communicating a vision beyond the initial implementation.

Communication is perceived by many to be a critical component, if not the most critical, to any change process. You cannot over-communicate in a change process, but good, clear and regular communication is important. Two additional pieces of advice that Heathfield offers are worth noting – build skills in communication and ‘Not trying to answer questions to which we had no answers yet ... maintaining credibility’. And she finally advises, ‘Expect tough times ahead; everyone expects that after the initiation event, it should go smoothly, but the most painful part is yet to come: the transition period. Recognizing this early on in the process will help weather the storms ahead.’

According to Sirkin et al. (2005), ‘Most experts are obsessed with ‘soft’ issues, such as culture and motivation’ but they argue that ‘focusing on these issues alone won’t bring about change’. They advise that organisations ‘also need to consider the hard factors’. They developed the DICE framework in this context as a simple formula for calculating how well an organisation is implementing or will be able to implement its change initiatives. The authors have used the following four factors to predict the outcomes and guide the execution of more than 1,000 change management programmes worldwide:

1. Project duration (particularly the time between project reviews).
2. Integrity of performance (or capability of project teams).
3. The level of commitment of senior executives and staff.
4. The additional effort required of employees directly affected by the change.

‘Not only has the correlation held, but no other factors (or combination of factors) have predicted outcomes as successfully.’

Dawson’s (1994) model of imperatives for change is based on a study of senior executives in the NHS. He distilled the critical success factors into the following four main key points. He strongly recommends that change programmes should include:
1. Elements of rationality and irrationality.

2. Iteration between decision and action.

3. Variable participation in decision and action from people from different positions in the structure.

4. Processes of learning and activity.

Garside (1998) focuses more on cultural and leadership aspects as critical elements in successful change and concludes:

- Changes for quality improvement should be driven by a ‘vision’ of what is to be accomplished. (A context should be established – the why and when – and content – or what is to be achieved … a fundamental change strategy should be adopted.)

- The culture of the organisation needs to be receptive to change to be embraced and to actually occur. (Perceptions and behaviours of individual stakeholders and recipients must be acknowledged, resistance overcome, and change must be supported organisation-wide in a learning organisation mode.)

- Focused attention is needed on the process of implementation to change. (Taking into account individual styles, motivations, and readiness to adopt change, the rational and the emotional, the need for an iterative and involving process, and a flexible approach to managing the process.)

Finally, successful change can be equated with what Senge terms profound change ‘… change that combines ‘inner’ shifts in people’s values, aspirations and behaviours with ‘outer’ shifts in processes, strategies, practices and systems … The organisation doesn’t just do something new; it builds its capacity for doing things in a new way – indeed, it builds capacity for ongoing change’. (Senge et al., 1999).
PART 8 CONCLUSION

This document has attempted to guide the reader through the jungle of literature on managing change. There is such a vast array of writings on the topic of managing change that it would be impossible to include all in one document. Instead we have included writings and theories that have made a significant contribution to our understanding of change and/or have shifted or called into question the dominant theories of the time.

From the early writings where there was an emphasis on attempting to control and predict change with a strong focus on planning and top-down approaches, there has been a shift towards an understanding of change as a dynamic process requiring participation from all levels of the organisation. Over time it has become increasingly obvious that there is no perfect model of change that can be applied in all situations. With this realisation and an increasing support for a contingency approach, the importance of culture in change processes has emerged as a dominant theme.

There are some enduring lessons emerging from the change literature that have stood the test of time. These include the necessity to have a clear vision and to communicate this effectively. The importance of planning has also been a feature since the early writings on change. The role of the leader and the contribution that both internal and external change agents can have has also received much attention. Systems theories of change have led to a greater awareness of the need to embed the change in the organisational context and has alerted us to the futility of attempting to achieve change in one section of an organisation while ignoring or hoping for little or no impact on the rest of the organisation. This in turn has led to an emphasis on assessment of ‘current state’ including values, beliefs, behaviours and the many other facets that make up the culture of an organisation. Organisation development has helped to highlight the benefits of ownership and participation of employees in change processes and also the necessity for a shared rather than an imposed vision. It has also helped to spread the message that effective and enduring change takes time.

More recent writings on the evolutionary nature of organisations have emphasised the potential for interaction between emerging change and planned change. Analyses of organisational failures have invariably shown that doggedly pursuing a plan that is not grounded in the reality of the organisation is a recipe for failure. Equally, an internally driven change agenda that does not take account of the broader environmental context, i.e. the political and economic climate, is unlikely to produce an effective organisation.
What is needed therefore is a balance between external and internal, between emergent and planned, between top down and bottom up. This calls for greater attention to assessment and planning. A variety of tools and techniques that can assist this process have been presented in Part 5. It also requires a degree of flexibility that enables the plan to be modified when a mismatch between it and the context of the change emerges. Often the first indication of this mismatch comes from those charged with implementing the plan. Too often such communication has been labelled ‘resistance’ and subsequently been ignored or dampened down. In Part 7 we advocate that instead change leaders need to work with resistance, incorporating dissenting voices into the change processes and learning to utilise ‘resistance’ as a barometer for the suitability of the plan to the context or environment. This approach is of course dependent on strong leaders who have the confidence to modify their vision and plan rather than doggedly sticking to a pre-planned course of action.

Finally, the key component in any change process is the people involved. They are the resource that will determine whether a change succeeds or fails. Recognising this and investing in building their capability to meaningfully engage in the process should be an essential element in any change process. With the recognition that change is an ever-present feature of the health care environment, this building of internal capacity to conduct organisational assessments, to communicate effectively, to motivate and lead change and to create an open environment that allows people to reflect on and learn from their mistakes and failures as well as their successes, is critical to the future of every health care organisation.
References


Guiding change in the Irish health system


